#25

NATIONAL HEALTH PLAN

HEARINGS
BEFORE A
SUBCOMMITTEE OF THE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE HOUSE OF REPRESENTATIVES
EIGHTY-FIRST CONGRESS
FIRST SESSION
ON

H. R. 4312 and H. R. 4313 (Identical Bills)
AND
H. R. 4918 and Other Identical Bills

Title I—Education of Health Personnel
  Grants and Scholarships
Title II—Medical Research
  Blindness and Eye Diseases
  Arthritis and Rheumatism
  Multiple Sclerosis
  Cerebral Palsy
  Epilepsy
  Leprosy (Hansen's Disease)
  Cancer, Heart Disease, and Poliomyelitis
  Medical Care Investigation Commission
  Research in Alaska
  Research on Family Aspects of Chronic Illnesses
  Survey of Sickness
Title III—Hospital Survey and Construction Amendment
Title V—Grants to States for State and Local Health Work
  Local Public Health Units

Dr Scheele
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MAY 20, 24, 25, JUNE 7, 8, 9, 10, 16, 17, 21, 22, 23, 24 29, 30,
AND JULY 6, 1949

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NATIONAL HEALTH PLAN

U.S. Congress. House. Committee on Interstate and Foreign Commerce

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NATIONAL HEALTH PLAN

FRIDAY, MAY 20, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to call, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Bills considered: H. R. 4312, by Mr. Dingell, and H. R. 4313, by Mr. Biemiller (identical bills)—To provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes.

Mr. Priest. The committee will please come to order. As previously announced, the hearings today are general hearings for 3 or 4 days at least, on what we have referred to as the over-all health bill. It is contemplated that all of the public health bills now pending before the committee will be heard at the appropriate places and under the titles and in connection with the subject matter of the various titles of H. R. 4312 and H. R. 4313. These are identical bills introduced by the gentleman from Michigan, Mr. Dingell, and a member of this committee, the gentleman from Wisconsin, Mr. Biemiller.

Under title I there is H. R. 3894, which provides for grants and scholarships and for medical aid to medical education. There is also a bill by our colleague, Mr. Biemiller.

Under title III of the over-all bill we have quite a number of bills 23 separate bills introduced. They will be heard in connection with that title as we reach that title in the specific hearings later on. Eleven of those bills have to do with multiple sclerosis; five have to do with arthritis and rheumatism research; seven others have to do with research in other various subjects, such as cerebral palsy, epilepsy, cancer, and other diseases.

Under Title III of the over-all bill we have quite a number of bills dealing with amendments to the Hospital Construction Act. These bills—14 of them, I believe, all together—most of them deal with amendments that will increase the percentage of Federal participation in construction of hospitals from 33⅓ to 50 percent. Others propose to raise the minimum contribution and others seek to make certain projects eligible whose construction was started prior to the effective date of the act. Most of these are considered as hardship cases.

Under title V of the over-all bill, there are two identical or similar bills, H. R. 267 and H. R. 785. These are known as local health service bills. They will be heard along with title V of the over-all bill.

Under title VI, there are two bills, H. R. 4465 and H. R. 4725. Then, in addition to the subject matter covered under this title, there is a group of school health bills that do not fall within any title of this bill. There are 14 of these school health bills, plus one Senate bill, S. 1411, that has passed the Senate and is now awaiting action by this committee.

All of these bills will be scheduled for hearing just before hearings on title VII.

Now, it is possible that S. 1411, the school health bill that has passed the Senate, will be heard at an earlier date than we would reach it ordinarily if we took these titles consecutively, because it has passed the Senate already.

There are a few other health measures pending before the committee that do not fall within the subject matter of H. R. 4312 and H. R. 4313. We hope to consider these at a later date.

We have announced hearings for today, for next Tuesday and Wednesday, for general statements on the over-all bill. Because of the limited time that we have and the fact that the House meets at 11 o'clock today, the morning session will be cut short. It might be necessary to extend general hearings one additional day before we get back to the specific titles.

We have no intention—the committee has no intention—of crowding out anybody who wants to be heard, either with a general statement or a more specific statement on any of the titles of the bill.

Without objection, at this point in the record, the Chair will submit a statement from the Federal Security Agency, covering H. R. 4312 and H. R. 4313, a report from the Treasury Department covering H. R. 4312, and a report from the Interior Department covering H. R. 4312 and H. R. 4313.

(The reports above referred to are as follows:)

FEDERAL SECURITY AGENCY,
Washington, May 19, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in response to your request of April 26, 1949, for a report on H. R. 4312 and H. R. 4313, identical bills "to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes."

Like their companion bill S. 1679 and their predecessors, H. R. 4730 and S. 1606 (79th Con.), and H. R. 3548 and S. 1320 (80th Con.), H. R. 4312 and H. R. 4313 would establish a Nation-wide system for the prepayment of medical costs, with provisions for comprehensive medical services and for coverage for most of the population who earn incomes, and with supplementary provisions through which public agencies could arrange for the coverage under the system of the needy and other noncovered groups. These provisions are contained in title VII.

The other titles of these bills carry provisions addressed to the alleviation of shortages of needed health facilities and personnel for financial assistance to schools and students for the support and extension of professional health education; for the development and expansion of public-health services and services for maternal and child health and crippled children; and for the improvement and expansion of medical research.

GENERAL CONSIDERATIONS

I shall take up first the proposal in title VII of the bills for prepaid personal health service benefits. This is the most basic of the new programs proposed in these bills, and is the one to which all of the other programs are in some degree supplementary. But before commenting on title VII in detail I should like to review some of the considerations which have led this Agency to endorse this proposal.

As you know the President has repeatedly recommended—most recently in his special message of last April 22—the enactment of legislation providing a Nation-wide system of health insurance as an integral and essential part of a comprehensive legislative program to improve the health of the people. On the basis of experience and knowledge acquired while serving as Federal Security Administrator, I can and do wholeheartedly endorse this recommendation.

When I became Federal Security Administrator I carefully reviewed the available evidence on medical-care needs, and I analyzed anew various proposals for meeting the costs of medical care. I found that there are ample grounds for the widespread agreement that our needs for personnel and facilities are large and urgent, and that they cannot be soundly met except in conjunction with a plan that will enable the families of our Nation to pay the costs of medical services through budgeted prepayments. There are differences of opinion as to the extent to which this should be done through voluntary or governmental action. As I pointed out in my report to the President, The Nation's Health: A Ten Year Program, I concluded, after analysis of the facts and arguments advanced for and against a Nation-wide system of health insurance, that there was no other possible way of bringing adequate medical service to the American people. I also concluded that a carefully designed legislative base would either completely avoid or greatly minimize most of the objections of any real substance that have been raised.

The report summarizes the essential elements of a Federal statute to establish the framework for a good health-insurance system. Briefly, a health-insurance statute should:

(1) Furnish basic policy guides—to the public, to the providers of service, and to the administrators—in terms of the objectives of the program, and the responsibilities of persons participating in it;

(2) Provide for insurance coverage on as broad a base as possible, and authorize arrangements for the inclusion of noninsured groups for whom public responsibility is already acknowledged;

(3) Specify prepayment rates based on ability to pay, and indicate the Government's share in the cost;

(4) Specify and describe the benefits to be received in return for the prepayments made, making those benefits as comprehensive as possible, directing their extension as rapidly as practicable, providing for fair rates and methods of payment to those who furnish the services, and requiring Federal-State-local cooperation in the administration of the program;

(5) Give explicit guarantees to insured persons, including their rights to receive benefits, to choose and change their own doctors, to have their personal records protected against unwarranted disclosure, to be protected against discrimination, and to make complaints and appeals;

(6) Give explicit corresponding guarantees to those who provide services, including their rights to participate in the program, to accept or reject individuals as patients, to have a voice in determining the methods and rates of payment, to exercise their professional judgment—without lay interference—in the treatment of patients, and to make complaints and appeals;

(7) Make special provisions to meet the needs of rural areas;

(8) Make provision for financial aid to professional education and research if such aid is not adequately provided in other legislation;

(9) Set forth the minimum conditions to be observed by States and localities in administering the program on a decentralized basis.

(10) State clearly the policies or formulas to be used in allocating funds among the States;

(11) Assign Federal administrative responsibilities to a small board of full-time members, including both professional and nonprofessional persons, and provide them with the assistance of an advisory council representing the public consumers, and interested professional groups, and give them ready access to advice on special problems by professional and technical committees;

(12) Link administration of this program with the existing system of old-age and survivors insurance to take advantage of existing administrative machinery for safeguarding funds, collecting of contributions, record-keeping, determining eligibility, and so on.

I also pointed out that a system of comprehensive Government health insurance would make the following fundamental contributions to better health:

It would largely solve the individual's problem of paying for medical care, and thus help encourage prompt care and preventive treatment.

Because it creates a stable and assured financial basis for health services, it will generate effective demand and assure the fastest possible increase in our supply of medical manpower, health facilities, and other essentials in all parts of the country.

Because insurance will pay for a patient's needs, doctors will be free to practice the highest quality of scientific medicine, uninhibited by the individual patient's ability to pay out of personal income for all the diagnostic and treatment services, hospitalization and nursing care which professional judgment prescribes.

Because insurance will abolish most of the financial obstacles to receiving medical care and help equalize community purchasing power, it will reduce the present large disparities in distribution of manpower and health facilities between lower-income areas and wealthier districts.

Because national health insurance will furnish a new and badly needed opportunity for coordination of all community and regional personnel and facilities, it will help build a more effective organization for providing the best in prevention, diagnosis and treatment.

I believe that title VII of H. R. 4312 and H. R. 4313, considered in conjunction with the other titles of these bills, would establish an insurance system that could accomplish these objectives. Its general pattern is thoroughly sound and workable. By building on our existing national social insurance system it would assure important economies in operation and a highly desirable link with other parts of a comprehensive social security program.

I turn now to consideration of particular provisions in title VII, and then to other titles of these bills.

Title VI—Prepared personal health insurance benefits

Title VII would establish a system of prepaid personal health service benefits, including physician's care in the home, office and hospital, hospitalization, laboratory and other auxiliary services, and some dental and home nursing benefits, for about 85 percent of the population. Except for operative dates, and a few important substantive changes, title VII of these bills is identical with title II of H. R. 3548 and S. 1320, Eightieth Congress, the predecessor bills.

In reports and testimony on the earlier bills, as well as in reports on other proposals for more limited medical care programs, this Agency has consistently urged favorable consideration of a national health insurance program designed to provide comprehensive services to as much of the population as possible. The necessity for such a program has grown no less in the intervening period during which medical and related costs have increased.

In our report on H. R. 3548, Eightieth Congress, we pointed out that while it would establish a program for making comprehensive health insurance available throughout the Nation as rapidly as available personnel and facilities would permit, it also recognized the necessity for taking steps to see that inadequacies in resources for services were overcome. It therefore required surveys of resources and needs in each State and the development of programs within each State to assure maximum use of existing resources and the progressive alleviation of shortages. It also contained (in sec. 256) special provisions for rural areas with disproportionate shortages. In H. R. 4312 and H. R. 4313 these provisions have been strengthened. The special rural area provision has been omitted from title VII and a new title IV, which will be discussed in more detail later in this report, has been added to authorize specific measures to be taken to correct inadequacies of personnel and facilities in all shortage areas. Under title IV the necessary initial steps could be taken by the National Health Insurance Board until State plans were approved and State surveys completed. Thus a program for the correction of already known shortages might be begun directly after enactment. I should like to suggest some slight changes in title IV and in section 742 which would carry over into the permanent State plan provisions for the alleviation of shortages similar to the measures authorized by title IV. The provisions for the allocation of funds in section 772 might also be recast to take account of the necessity for positive continued programs to overcome the inadequacies discovered by the surveys.

Title VII wisely repeats the general division of administrative responsibilities found in H. R. 3548, Eightieth Congress. The guiding principle applied throughout most of the administrative provisions is that immediate operational responsibility should rest with local authorities within the framework of a planned State program which would establish uniform standards and procedures but at the same time allow sufficient flexibility for adjustment of the program to meet local situations. The Federal responsibility would include collection and allotment of funds, determination of insured status, and the establishment of basic policies and minimum standards as necessary to the fulfillment of the Federal guaranty. At every level of administration the bill provides for the active participation of advisory bodies composed of representatives of the recipients of service and of interested professional groups. The effectiveness of the advisory councils is heightened by providing them with the assistance of professional and technical advisory committees.

H. R. 4312 and H. R. 4313 depart from the earlier administrative pattern in the revision of section 719 (c). That section makes provision for maximum limits upon the number of eligible individuals to whom a qualified person might undertake to render health-service benefits, if such limitations are necessary in order to maintain a high quality of services. Section 219 (c) of H. R. 3548, Eightieth Congress, authorized the State agency to fix such maximums for the State or for classes of health service areas within the limits of maximums established by regulation of the National Health Insurance Board, after consultation with the National Advisory Council. The State agency might reduce the limits for a particular health service area upon recommendation of those who furnished services in that area. Section 719 (c), as revised, authorizes the fixing of maximum limits by the local administrative officer or body only, and then only upon recommendation of the local professional committee.

The new section 719 (c) thus not only omits all the necessary safeguards to assure that both the providers and the recipients of service will be protected by comparable rules in comparable situations, but it assigns to an interested professional group all responsibility for initiating action to control abuse in this area. The wisdom of this revision is seriously questionable, and I recommend the restoration of the original section which provided for the establishment of uniform general rules for the country, to be adapted by the State agency to the situation in the State as a whole, and subject to further adaptation to fit local situations. While the old section provided for the participation of interested groups in the estblishment of the maximums it quite properly left the responsibility for the action taken with the public agency which was also responsible for other aspects of the program.

The coverage, eligibility, and financial provisions of title VII are substantially identical with those of H. R. 3548, Eightieth Congress, except that the title now contemplates the coverage of earnings up to $4,800 and an annual appropriation measured by 3 percent of earnings up to that amount. The corresponding figure in H. R. 3548 was $3,600.

This Agency again urges the broadest possible coverage—certainly as comprehensive as the coverage provisions in H. R. 2893, the Administration bill to extend and improve the old-age and survivors insurance program. The provisions for inclusion of the financially needy through arrangements made on their behalf by a public agency will also need to be scrutinized in the light of any amendments of the public assistance titles of the Social Security Act. In the event of passage of H. R. 2892, now being considered by the House Committee on Ways and Means, section 782 may be unnecessary, and section 705 might need revision.

The authorization of grants for education and training contained in section 273 of H. R. 3548, Eightieth Congress, has been scaled down, both in content of the program and in the financial support provided. Section 773 is now addressed to the correction of shortages of personnel needed for the medical-care program. It no longer contains provisions for assistance to research, and its education and training features are limited to increasing the availability of such opportunities for persons who are either engaged in or will undertake to engage in the administration or provision of personal health service benefits. Section 773 would operate to supplement, for the needs of the particular program, the general medical education and research programs contained in titles I and II.

In concluding my discussion of title VII, I should like to suggest to the committee a careful study of the allotment provisions in section 772, in particular the desirability of developing more specific methods and criteria for the division of funds among the States. I shall be prepared, at a later date, to discuss with the committee some proposals for such methods and criteria.

Finally, I should like to reserve the privilege of making more detailed comment and suggestions on particular provisions of title VII.

Title IV—Special aid for rural and other shortage areas

Title VII of these bills (secs, 702 and 742) requires that each State make initial and subsequent periodic surveys of the resources and needs of the State, on the basis of which the State program under title VII would be developed and modified to correct maldistributions and other inadequacies. At the same title IV, part A, proposes a program to correct and alleviate acute shortages of basic services as rapidly as possible after enactment, through measures which would be adjusted to other remedial programs, such as the hospital construction program and the proposed program for Federal aid to medical education, and to the findings of State surveys as they are completed. Working agreements with appropriate agencies within the States would be utilized in operations during the interim period after enactment and before benefits become available, and, after each State plan is approved until title VII, the program would be carried out through the agency administering the State plan.

The measures authorized by part A of title IV include (1) grants and loans to individuals and organizations for construction, equipment, and operating costs of needed facilities and for guaranteed minimum incomes to needed health personnel to encourage them to practice in shortage areas; and (2) traveling clinics and special ambulance and information services to obtain maximum utilization of existing facilities and services. This program obviously offers great possibilities for early constructive action to alleviate known critical shortages of essential services. However, separation of this special program from the insurance title (VII) results in certain technical difficulties calling for some specific revisions of title VII and of part A of title IV, which I have already referred to above in the course of the discussion of title VII of the bills.

In connection with this part, the attention of the committe is invited to the President's recommendation in his special message to the Congress of April 22, 1949, that provision be made for aid in the establishment of private health centers, diagnostic clinics, and group practice clinics, such aid to be afforded in the form of Government guarantees of loans similar to the mortgage guarantees the Government provides for private housing.

Part B of title IV would provide for a 5-year experimental program of financial assistance to farmers' medical care cooperatives. The cooperatives assisted would be selected on the basis of preliminary surveys and would be limited to a total of 50 in any one fiscal year and not more than two in any one State. Grants would be available for the costs of providing care, including the cost of facilities.

The proposal in part B of title IV will require considerable further study and development. Although it is intended "as a means of demonstrating the practicality and effectiveness" of such health cooperatives, the objectives of the program need clarification. Neither the definition of eligible cooperatives nor the grant conditions furnish reliable guides for selection of the cooperatives which are to be assisted. If an experiment of such limited proportions is to be of value, it is essential that the chief emphasis of the program be made clear.

For example, the development of group practice is one of the most important steps toward improvement of the quality of medical care, and financial assistance to group-practice units serving farm groups, especially assistance in the acquisition of facilities, and general encouragement for the organization of such units which could offer comprehensive services might go far toward demonstrating the feasibility of this sort of practice in these areas. Unfortunately, the provisions do not mention development of group practice as an objective. The results of such an experimental program, as well as the methods and policies applied in its administration, might well be very different depending upon whether our major concern is to be improvement of the quality of care, financial soundness of the particular projects, geographic distribution which will be most likely to alleviate present shortages of services, or trial of a wide variety of methods of furnishing services.

The committee will probably wish to consider also the necessity for establishing clearer policy guides for this program in order to prevent overlapping and duplication of construction programs operating under either the Hospital Survey and Construction Act amendments proposed in title III or under part A of this title and of the medical-care program authorized under title VII.

TITLE I—EDUCATION OF HEALTH PERSONNEL

The proposals in this title are similar to proposals made in H. R. 3894 upon which we are submitting a separate report; we will discuss in greater detail the various provisions of this title in that report.

Part A of this title would amend title III of the Public Health Service Act by adding a new part authorizing grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions. Part B would authorize a grant program to assist States to develop and operate vocational education programs for practical nurse training.

The program authorized by part A would provide (1) grants to approved public and nonprofit teaching institutions for costs of instruction, and for costs of construction and equipment to assist in the establishment of new schools and improvement and expansion of existing facilities; and (2) payment to States for scholarships to approved schools to be awarded to persons selected by the State agency in accordance with the State's approved plan.

Payments to schools for costs of instruction would be based upon enrollment—a fixed amount, varying with the field in which instruction was offered, for each student up to the average enrollment for the last 3 years, and a larger amount for each student in excess of past average enrollment, the larger amount being an approximation of the net cost (actual cost of instruction less tuition fees) which would be sustained by the average school in case it enrolled a new student. Grants for construction of school facilities would be made in the order of their estimated value in alleviating shortages of trained personnel and, in the case of hospital facilities, may only be made after approval of the project under the Hospital Survey and Construction Act. Grants may not exceed 50 percent of the school's total instruction costs, or the total cost of constructing the project, as the case may be.

Shortages of professional personnel exist in all health fields. In many places these shortages are acute. At the same time the serious financial situation of most professional health-training institutions is an effective obstacle to their expansion or to the establishment of new ones. With the rising costs of medical education, income sources barely adequate in past years—income from tuition fees, endowments, and gifts—can no longer be relied upon to furnish a major part of their necessary support. Space does not permit a recital here of estimated shortages based on the present rate of output of teaching institutions in all these various fields, but there is no longer any serious question but that the rate of output must be substantially increased through greater utilization of existing facilities and through construction of new ones, where needed, and that means must be devised as soon as possible to stabilize the financial condition of health and medical training institutions.

A National Council on Education for Health Professions would advise the Surgeon General on administration of this program and surveys and studies are provided for in order to provide a base for necessary modification of the program. Recommendations would be required to include recommendations as to adjustment of the amount of the payments for costs of instruction, the amounts stated in the bills being applicable only to the first three fiscal years. This is an extremely important provision since we have not now reliable data by which to judge the adequacy of these amounts.

Scholarships would be conditioned upon acceptance of the applicant by an approved school and an agreement by the appointee to serve upon completion of his training, 1 year for each two academic years during which he received the scholarship, by (1) rendition of professional service for the State or a political subdivision, (2) practice of his profession in a shortage area designated by the State agency, or (3) with the approval of the State agency, practice of his profession on full-time active duty in a medical agency, or unit of the United States. Funds appropriated for scholarships would be allotted among the States, one-half on the basis of population and one-half on the basis of relative needs for additional personnel.

Provisions of aid to students as well as to institutions is an essential part of a full program of aid to education in the health professions. Scholarship aid would serve to reduce or eliminate inability to pay a factor governing access to the health professions, thus reducing the inequality of opportunity now so great in view of the high cost of professional health training, and providing an inducement to qualified students to take this training. Through requiring those who accept scholarships to agree to work after completion of their training where the need for their services is greatest, these provisions can, and in this title have been aimed more directly toward attainment of a general objective of the bills—increasing the supply of professional services in areas most inadequately served.

Apart from the principle involved in conditioning scholarship aid upon the student's agreement to serve in shortage areas or elsewhere at Government direction, there is considerable doubt whether such a requirement will prove effective in practice. Private foundations have at times undertaken to secure from students whom they have aided commitments to serve in rural areas. Few of the students observed the commitment. Experience under the few State programs which have similarly conditioned aid to medical students is not yet available because of the newness of those programs. Probably, the direct inducements for allocation of doctors contained in title IV of these bills will prove to be more effective than the conditions attached to receipt of scholarships.

Consideration should also be given to enlarging the kinds of service which would be acceptable in relieving students of the obligation to repay scholarships, to include others such as service in teaching, research, and the like.

We recommend that Federal aid to schools for construction and instruction be extended to Puerto Rico and the Virgin Islands, in keeping with the rest of this title.

Provision for the training of practical nurses is likewise important in order to increase the numbers and improve the capabilities of this type of health personnel and in turn help to reduce the hospital and home-nursing load which is now being carried to an unnecessarily great extent by professional nurses. Only a relatively small number of practical nurses receive training under existing vocational education legislation.

The program for practical nurse training outlined in part B seems generally well adapted to achieve the purposes it seeks to achieve. Most people familiar with nursing education problems believe that the most effective means of providing such training is through vocational schools, of courses, of less than college grade. Programs for practical nurse training are now being carried on by State boards of vocational education with some Federal financial assistance under existing legislation authorizing grants for vocational education administered by the Office of Education, but in some States this type of training receives a disproportionate emphasis in the vocational education program. A separate program, with a separate appropriation and specific matching requirements, would encourage the establishment of practical nurse training courses in all States and so help to meet some of the demand for nursing care more quickly.

TITLE II—MEDICAL RESEARCH

Title II of H. R. 4312 and H. R. 4313 would vest in the Surgeon General of the Public Health Service, with the approval of the Administrator, the authority to establish one or more research institutes, together with one or more advisory councils, whenever he determines such action necessary to further research and training in some particular disease or group of diseases, including poliomyelitis, diabetes, rheumatism and arthritis, multiple sclerosis, cerebral palsy, and epilepsy. If and when the objectives of establishing such institutes have been achieved, the Surgeon General would be authorized to discontinue them. Finally, the title would authorize the establishment within the Public Health Service of not more than 30 positions for specially qualified research personnel, such positions to carry salaries of from $10,000 to $15,000 per year.

The Federal Security Agency believes that the authority granted by this title is essential if further development of the research activities of the Public Health Service is to be guided along the most productive lines.

Congress has established or authorized the establishment of four national medical research institutes devoted to research and training in particular diseases or conditions—the National Cancer Institute, the National Heart Institute, the National Institute of Mental Health, and the National Institute of Dental Health. These institutes are serving as national centers for a concerted attack upon the diseases which they were established to combat. Their establishment has led to proposals for the establishment of numerous additional institutes. In the current session of Congress, bills proposing the establishment of institutes for rheumatic diseases and arthritis, cerebral palsy, multiple sclerosis, and epilepsy have already been introduced.

While I am in complete sympathy with the objective of expanded research in all of these specific disease entities, I believe that the point of diminishing returns has probably been reached with respect to statutory research institutes in the

Public Health Service. I am gravely concerned lest the trend toward separate research establishments for more and more specific disease entities undermine the effectiveness of the research program as a whole. Above all I am convinced that statutory establishment of administrative subdivisions interferes with the organizational flexibility which is essential to cope with new developments and discoveries in the several fields of medical research.

In addition, I believe that if every expansion of some new research field is accompanied by the establishment of one more institute, the result will inevitably be an extravagantly costly structure, with unavoidable overlapping and friction.

Title II of these bills would provide a means of obtaining the advantages and avoiding the disadvantages of statutory categorical institutes. The flexibility inherent in the terms of this title, with the amendments proposed below, would effectively avoid the rigidity, segmentation, and administrative complexity that would follow the establishment of a series of additional research institutes through statutory action. At the same time, action appropriate to specific diseases could be taken, the importance of these diseases to the national welfare could be effectively established, and the base of support for medical research into the problems of specific diseases widened.

We would like to suggest three modifications in this title which, we believe, would render it more effective to accomplish its purpose. First, we urge that the Surgeon General be empowered to appoint, with the Administrator's approval, additional National Advisory Councils to advise on research and training in particular diseases or conditions, even if he does not establish corresponding institutes. The major problem with respect to a particular disease may be identification of the areas of research that appear to be potentially most productive. It should be possible in this circumstance to set up a National Advisory Council to recommend broad research plans for the consideration of the Surgeon General. Such a group might also advise the Surgeon General as to whether expanded research should be incorporated in existing research organizations or placed in a new institute.

We also urge that the Surgeon General be authorized to expand the functions of existing institutes and national advisory councils in lieu of establishing additional institutes and councils. It should be possible to group an expanded research program in a particular disease or group of diseases with related programs already in existence. Finally, we recommend that all new authority as respects research and training, and grants therefor, which the bills would confer on the Surgeon General in connection with any new institute, be made equally applicable to existing institutes. Such authority is essential to the attainment of the general objectives of the title.

The second major objective of the title—authorization to pay salaries ranging from $10,000 to $15,000 to not more than 30 specially qualified workers—is critically important to the proper fulfillment of medical research responsibilities already placed upon the Public Health Service by Congress.

The full potentialities of the whole research staff of the Public Health Service can be brought out only if those who guide its research activities combine research talents of the highest order with ability to stimulate others and to administer large programs. This combination of talents is rare. Persons who possess them command high salaries.

It will not be possible for the Service to pay salaries competitive with the compensation which such people can secure outside the Government. But the research opportunities in the Public Health Service are so challenging to men of the highest caliber that they will make some sacrifice in income for the chance to do work to which their lives are dedicated. What they must have is an income that will make the financial sacrifice bearable. Payment of salaries up to $15,000 per year to a limited number of scientific and professional persons engaged in research and development activities of the Public Health Service will make it possible to keep men of the highest attainments who cannot afford to turn down opportunities to double or triple their income, and to attract men who will sacrifice money but who cannot afford to work at the prevailing $10,000 salary ceiling. The maximum possible total cost of the proposed salary increase is $150,000 per year. This is a small investment in terms of the resulting increase in the productivity of the Federal Government's medical research program.

TITLE III—HOSPITAL SURVEY AND CONSTRUCTION AMENDMENTS

Title III, generally speaking, covers the same subject matter as H. R. 2176, H. R. 2567, H. R. 3025, H. R. 3737, and H. R. 3515, also pending before your Committee. All three bills would amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act) to extend the duration of the hospital construction program, double the Federal allotment to the States, increase on one basis or another the Federal share in the cost of projects, endeavor to assure that the State agencies have adequate funds to administer the program properly, and authorize the Public Health Service to conduct research, experiments and demonstrations relating to the effective development, utilization and coordination of hospital facilities and services and to make grants for such purposes.

We are completely in accord with the general objectives of all these proposals but would make suggestions for changes in certain particulars. Inasmuch as a detailed report is being submitted relative to the other bills referred to above, we will in this report dwell mainly on those provisions of title III of H. R. 4312 and H. R. 4313 which differ from analogous provisions in the other bills.

The other bills would extend allotments through the fiscal year 1955; title III through the fiscal year 1957. Inasmuch as the program whether extended to 1955 or 1957 will meet only a small part of the country's need for additional facilities, we regard the longer extension of the program as the more desirable.

The other bills change the Federal share from a uniform one-third of the cost of a project to a percentage equal in the case of each State to its allotment percentage—a figure which ranges from 33⅓ percent to 75 percent, depending upon the State's per capita income in relation to the national per capita income. Under title III of H. R. 4312 and H. R. 4313 the State agency would have the alternative of (1) determining that the Federal share might vary among projects within the State in accord with equitable standards taking account of need, economic status of areas and other relevant factors, in which case the Federal share for each project could be determined by the State agency within a range of 33⅓ and 66⅔ percent, or (2) the State agency might determine that all projects within the State should receive the same degree of Federal aid in which case it could set the percentage of Federal participation as it so wished between the limits of 33⅓ percent, and the State's allotment percentage or 66⅔ percent, whichever was lower.

We believe that there is need to increase the Federal share if hospitals are to be built in areas which are in most urgent need of them—these areas in general being rural areas of low economic resources. Title III gives to the State a maximum of discretion to use the Federal allotment in a manner best suited to its situation and hospital construction program. It would enable the State agency, even in a relatively wealthy State, to give a large degree of Federal aid to a poor community—one which could not build a hospital if the degree of Federal participation was limited to the State's allotment percentage. For these reasons we regard the provisions of title III more desirable than those of the other bills.

The other hospital construction bills provide that the Surgeon General may withhold certification of funds to projects in a State if he finds that adequate State funds are not being provided annually for direct administration of the State plan. Adequate funds are defined as $15,000 or 2 percent (1 percent in some of the bills) of the total to be expended under the program.

Title III uses a different approach to assure that the State agencies will have adequate funds for effective administration of the program. It provides for grants to the States for expenses of administering the State plan, including continued survey and planning activities. Total grants to States for this purpose would be slightly over a million dollars a year, and must be matched by the States on a 50–50 basis.

We believe that the approach of title III of H. R. 4312 and H. R. 4313 is by far the more desirable. We doubt that any formula can be devised which would give the exact amount which a State should appropriate in order to provide adequate funds for administration of its program. Inevitably the amount would be less than needed in some cases, more than needed in others.

Instead of attempting to force the State to appropriate adequate funds for administration through the threat of withdrawing aid for construction if they do not, title III employs the more desirable approach of giving financial assistance to the States for administrative expenses contingent upon their appropriating at least equal amounts.

We therefore recommend against enactment of the administrative expense provisions of the other bills and for enactment of those of title III.

Title III also differs from the other bills in that it amends the definition of hospitals to include "facilities for the group practice of medicine or dentistry (or both) by or for a cooperative or other nonprofit corporation or association." This would mean that group practice clinics owned by cooperatives or other nonprofit associations and not associated with a hospital could receive aid for construction.

We believe that the development of group practice arrangements, i. e., where physicians come together into groups instead of practicing each physician by himself, will help immeasurably to improve the quality of medical service and lower its cost. This provision will give encouragement to the development of group practice and we consider it a desirable one. We should favor broadening of the above definition so as to include diagnostic clinics and so as to leave no doubt that diagnostic clinics and group practice facilities under either nonprofit or public auspices would be eligible for Federal aid.

The question of the general priority to be assigned group practice facilities in relation to the various types of hospitals and to health centers may present serious problems since it is very difficult to compare the needs for such facilities and for hospitals as the term is generally understood. The language of the bill does not furnish any guidance in this respect but leaves the principles to be established by the Surgeon General's regulations. Under these circumstances the Surgeon General may adopt the course of setting a maximum proportion of the State's allotment which may be made available for assistance in the construction of such facilities. While it is believed that this can be accomplished under the language of the bill as now drawn, the committee may wish to give consideration to the policy questions involved.

Title III of H. R. 4312 and H. R. 4313 and H. R. 3737 and H. R. 3515, would make the increased rate of Federal participation effective for all projects approved since August 13, 1946, the effective date of the Hospital Survey and Construction Act. The other bills (H. R. 2176, H. R. 2567, and H. R. 3025) would make the increased Federal share retroactive only to January 1, 1949.

The Agency questions the wisdom of the retroactive features of all these bills. These features would introduce a new principle in Federal grant-in-aid procedures. The objective of increasing the rate of Federal participation is to give greater encouragement and inducement to the States and communities to construct more needed hospitals. That objective is not furthered by a retroactive provision applying the increased rate to construction to which the States and communities are already committed.

On behalf of a January 1, 1949, effective date, it may be argued that it is necessary, or at least expedient, in order to avoid the danger of having applicants postpone their construction projects until the enactment of the new bill. However that may be, no such argument can be made for a provision which is retroactive to August 13, 1946, and we strongly oppose this provision in title III of H. R. 4312 and H. R. 4313 and in other bills which similarly provide.

Title III contains several amendments of the Hospital Survey and Construction Act which are, for the most part, of a technical or clarifying nature. These are all in accord with recommendations of this Agency, and it is believed that they should be enacted.

TITLE V—GRANTS TO STATES FOR STATE AND LOCAL HEALTH WORK

Title V of H. R. 4312 and H. R. 4313 amends the existing provisions of the Public Health Service Act with respect to grants for State and local health work. Under the provisions of this title separate grants for specialized public-health programs would be eliminated as legislative entities and in their place would be substituted a single grant to the States for all of their public-health programs, including those currently aided through existing grants under the Public Health Service Act. The Surgeon General would be authorized to establish by regulations percentages of a State's allotment which would be available only if its over-all State plan included provisions for satisfactory services in particular aspects of a public-health program. Thus special attention would be given, not only for local health units, but for all existing statutory programs and for others not yet established.

Congress is authorized to appropriate such amounts as may be necessary to carry out the purposes of the title. From the sums appropriated the Surgeon General would make allotments to the States on the basis of their population, per capita income, and special health problems. Each State would be eligible to receive from its allotment a percentage of the total expenditures which are made under the State plan. This percentage would vary among States from 40 to 75 percent on the basis of the relative per capita income of the State.

There are also pending before your committee two bills, H. R. 267 and H. R. 785, providing grants to States for the development and maintenance of local health units. While I shall submit a separate report on these bills, I would like here, in view of their similar objectives, to include some comments comparing these bills with title V of H. R. 4312 and H. R. 4313.

This agency is in complete accord with the objectives in all of these bills of extending and improving public-health services. The bills differ largely in the scope of activities to be aided by the grant program and in the methods for accomplishing these objectives. H. R. 267 and H. R. 785 would add to the existing special grants another new grant category directed solely to basic health services in local health units. Title V of H. R. 4312 and H. R. 4313 would eliminate the present satutory earmarking of appropriations for specialized grants and provide funds for local health services as well as for other special public health programs in the form of a single grant to the States with authority for the Surgeon General by regulations to establish requirements in particular programs which the States must meet in order to qualify for payments.

The provisions of title V would avoid the complexity and rigidity inherent in categorical grants and permit the States greater flexibility in the administration of the various programs aided by grants administered by the Public Health Service. These provisions would enable the States to develop more complete and better balanced programs, and to adjust their programs more closely to their special needs. We recommend, therefore, that the objectives of H. R. 267 and H. R. 785 be accomplished through the methods authorized in the more comprehensive provisions of title V of H. R. 4312 and H. R. 4313. However, if either this or the succeeding title were to be redrafted as separate bills, certain important changes would become necessary which I would be glad to suggest to the committee should it decide to pursue such a course.

TITLE VI—RESEARCH IN CHILD LIFE AND GRANTS FOR MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

Ttitle VI would establish a new program of grants to public and nonprofit institutions for research and training in child life and development, and would improve and expand the present programs of grants to the States for maternal and child health and crippled children's services.

Part A of title VI would authorize a broad program of research and investigation for all phases of child life and development. This program would be carried out by grants to universities, other research institutions and public and other nonprofit agencies for research projects (including costs of construction, equipment and maintenance of necessary facilities) and research fellowships, and for training and instruction including traineeships, as well as by the provision of training and the establishment of fellowships and traineeships within the Children's Bureau.

Research in child development and the community aspects of child life lays the foundation for wise planning of necessary maternal and child services in the health and welfare fields. Workers in State and local agencies, and others concerned with the provision of such services, have felt an urgent need for increased research opportunities, especially opportunities for integrated research activities which require the combined skills of different kinds of scientific investigators—such as sociologists, anthropologists, psychologists, pediatricians, psychiatrists, and other experts in the health, welfare, and education fields. Greater training opportunities in the fields of child development and child health and welfare are also essential.

Part B of title VI is a complete substitution for parts 1 and 2 of title V of the Social Security Act which authorize grants to States for maternal and child health services and crippled children's services. In brief, it would increase the amounts authorized for the fiscal year 1950 from $11,000,000 to $25,000,000 for maternal and child health services, and from $7,500,000 to $25,000,000 for crippled children's services, and for subsequent fiscal years would leave the amounts to annual congressional determination. It would provide an allotment formula based on (1) the number of children in each State, (2) the per capita income of the State, and (3) special factors relevant to the extent of particular problems in the respective States. It would provide for variable matching based on relative per capita income. It would authorize the Administrator to appoint special advisory committees in addition to the Advisory Council established under part A, and require him to consult with representatives of the

State agencies before making regulations; and it would provide uniform and more specific requirements for plan approval.

Among the new plan requirements are: Administration of both programs by the same State agency within 5 years after enactment; State standards for the care and services to be provided; progressive development of the programs with immediate emphasis upon areas of greatest need; prohibition of discrimination on the ground of economic status, race, religion, creed, color or national origin; provisions for safeguarding confidential information; provisions for study and evaluation of the effectiveness of the programs; and provision for appointment of advisory councils and technical advisory committees.

In December 1948 there were 31,000 crippled children waiting for care which could not be provided because of limited funds. Special programs, such as care of children with rheumatic fever, cerebral palsy, or epilepsy and provision of hearing aids and glasses, are in many cases extremely limited. Additional funds are necessary to make new skills and knowledge available on behalf of children throughout the country through the organized maternal and child health programs. Limitations of trained personnel and facilities must also be overcome and this too would be an essential part of an expanded program.

The modifications in the financial and administrative provisions are recommended as improvements in the operational structure of the program. In the main they would add to and clarify State responsibilities and participation in the programs, and help to equalize their financial burdens with respect to programs for mothers and children.

I am advised by the Bureau of the Budget that it has no objection to the submission of this report to your Committee since the objectives of H. R. 4312 and H. R. 4313 are in accord with the President's program as outlined in his message of April 22, 1949. The Bureau has indicated, however, that this advice does not involve commitment in terms of the President's program to every detail of the bills.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

TREASURY DEPARTMENT,
Washington, June 22, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

MY DEAR MR. CHAIRMAN: Further reference is made to your letter of April 26, 1949, requesting the views of this Department on H. R. 4312, a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes.

The President in his health message of April 22, 1949, to the Congress has pointed out the need for a national health program to relieve the present shortage of, and equitably distribute over the country, doctors, dentists, and other professional people, as well as hospitals, health centers and clinics, and to furnish adequate medical care to the tens of millions now suffering from such shortages. He proposed a program of prepaid personal health insurance to assure that "proper medical care will be economically accessible to everyone covered by it in the country as well as in the city, as a right and not as a medical dole."

H. R. 4312 implements the President's message. It authorizes Federal appropriations to expand the facilities of the various medical, dental, and other professional schools, and increase the student body thereof, to establish institutes to conduct research and experiement in various diseases, to extend the duration of and increase the aid for hospital construction, to relieve the medical and health shortages in rural and other shortage areas through grants for medical and health centers and financial assistance to farmers' health cooperatives, to aid State and local health services for the control of diseases constituting special health problems, to increase Federal aid for research in child life and development and to extend aid to the States for the expansion and improvement of maternal care and of services for the health of infants and crippled and physically handicapped children. In addition, the bill provides for a program of personal health insurance benefits with decentralized administration

This Department is in favor of the general objectives of the bill but is not in a position to comment with respect to the adequacy or inadequacy of the specific benefits provided thereby.

It is noted, however, that the bill does not provide a method of financing the program. Doubtless, it is contemplated that this problem will be considered by congressional committees having jurisdiction over taxation. In this connection, it may be desirable to coordinate the contributions for prepaid medical care with other social security measures so that the financing of the entire social security program might be accomplished in such a way as to promote the objective of full production and full employment. Certainly, from an administrative viewpoint, it would be desirable to define the terms in the bill which also appear in the Social Security Act and the Federal Insurance Contributions Act in identical language, wherever appropriate.

The Director, Bureau of the Budget, has advised the Treasury Department that there is no objection to the presentation of this report.

Very truly yours,

E. H. Foley, Jr.,
Acting Secretary of the Treasury.

United States Department of the Interior,
Office of the Secretary,
Washington, D. C., September 1, 1949.

Hon. Robert Crosser,
*Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.*

My Dear Mr. Crosser: This is in reply to your request for the views of this Department on H. R. 4312 and H. R. 4313, identical bills, to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes.

The proposed legislation would put into operation a comprehensive national program to improve the health of the people of this Nation by bringing adequate health services within the reach of all our people. I fully support the objectives of this legislation.

The Department of the Interior, as you know, has general supervision over various Territories and island possessions of the United States, and it is concerned with the exclusion of these areas from certain of the proposed programs outlined in these bills.

Specifically, the bills fail to include Alaska, Hawaii, Puerto Rico, and the Virgin Islands in that portion of title I, part A, which provides for Federal aid to medical, dental, dental hygiene, nursing and related public-health schools, and exclude Puerto Rico and the Virgin Islands from the benefits of title IV, which would provide special aid to rural and other areas where medical personnel are in short supply, and title VII, which sets a system of prepaid personal health insurance benefits.

Section 372 (e) of title I, part A, of the bills would limit Federal assistance to medical and other public-health schools in the continental United States, thus making schools in Alaska, Hawaii, Puerto Rico, and the Virgin Islands ineligible for such assistance. I know of no reason why this aid should be limited to schools in the continental United States. The shortage of physicians, dentists, dental hygienists, nurses, sanitary engineers, and other health personnel which this legislation is designed to eliminate is even more pronounced in the Territories and possessions than in the continental United States; particularly is this so in Puerto Rico, where for a population of approximately 2¼ million there are only 728 licensed physicians and approximately 1,438 licensed graduate nurses. According to Public Health Service standards at least 2,000 physicians and about 4,000 nurses are required to meet the minimum health needs of the people of Puerto Rico.

In order to combat this shortage the government of Puerto Rico is planning in the very near future to establish a school of medicine in Puerto Rico. The medical school is an integral and indispensable part of the insular government's effort to cope with the health problems of the community. The extent of that effort is illustrated by the fact that out of a total budget of approximately $62,000,000 appropriated by the insular-legislature for 1950, approximately 25 percent, or $15,000,000, is set aside for health purposes. Moreover, the insular government is now spending over $225,000 in medical scholarships alone. I believe that

Puerto Rico deserves and should receive Federal assistance for the construction and equipping of this school, and for the meeting of part of the cost in instructing medical students, in the same manner and under the same formula as such assistance would be furnished to schools in the continental United States. The same principle, of course, should apply to Alaska, Hawaii, and the Virgin Islands. To accomplish this objective, I recommend that these bills be amended as follows: On page 16, line 9, delete the words "the continental United States" and substitute in lieu thereof the words "a State."

The other matter which I should like to raise at this time is the omission of Puerto Rico and the Virgin Islands from the provisions of titles IV and VII of these bills. A program of prepaid personal health insurance and special aid to rural areas can be effectively administered in the islands and would be of great benefit to the people of these areas. In order to make the provisions of titles IV and VII applicable to Puerto Rico and the Virgin Islands, I recommend that the bills be amended by inserting on page 160, line 22, before the word "and," the words "Puerto Rico, the Virgin Islands." Since participation under title IV is dependent on participation under title VII, no specific amendment to that title is required for Puerto Rico and the Virgin Islands to be included under its provisions.

The people of Alaska, Hawaii, Puerto Rico, and the Virgin Islands are citizens of the United States; as such their health and welfare are as important to the strength and well-being of our Nation as that of the citizens of the 48 States.

I want at this time to urge the adoption of the amendments which I have proposed. I believe that their adoption would not only be in accord with the basic objectives of this legislation, but would, as well, contribute to the maximum effectiveness of the national health program.

In view of your request for an immediate report on these bills, this report is being sent to you prior to its submission to the Bureau of the Budget. Therefore, no commitment can be made concerning the relationship of the views expressed herein to the program of the President.

Sincerely yours,

William E. Warne,
Assistant Secretary of the Interior.

Mr. O'Hara. Mr. Chairman, I wonder if copies of that might be made available for the members of the subcommittee?

Mr. Priest. The Chair might state that we will attempt to supply or have copies of the Federal Security Agency's statement prepared for members of the committee. Also there will be, during the hearings, a representative of the Agency testifying before the committee.

We are happy to have this morning, our colleague, the gentleman from Michigan, Mr. Dingell, who is the author of H. R. 4312, who has for many years been identified with and interested in any legislation relating to improvement of the Nation's health.

Mr. Dingell is our first witness. We are very happy to have you at this time, Mr. Dingell.

STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Dingell. Mr. Chairman and members of the committee, I am delighted to have this opportunity to appear before you on the bills Representative Biemiller and I have introduced proposing a national health program including a Nation-wide system of health insurance. I have had bills of this kind pending in Congress for many years, but this is the first time hearings have been held in the House for their consideration. These hearings, therefore, mark a long step forward in the march toward enactment of health insurance legislation. I believe we are on the way, and the road ahead will be much shorter than the road we have already traversed, particularly in view of President Truman's strong personal support for the legislation.

Most of you have heard my speeches on the subject of national health insurance and so I will not take up your time now by making another one. A representative of the Federal Security Administration will follow me and go into some detail on the bill and the need for it. Instead, I want to talk about something else in connection with this bill—the tremendous, multi-million-dollar campaign of propaganda and misrepresentation—as well as high pressure lobbying being conducted against it by the American Medical Association. It is important for you to consider this in order to weigh the testimony you will receive in these hearings.

I believe you all know the background. The AMA, along with many others, was surprised and shocked when President Truman won the election last fall. In view of the fact that he had campaigned at least partly on the issue of national health insurance it become panicky and decided that the legislation was sure to be enacted. So the ruling element within the AMA set out deliberately to thwart the will of the people.

In order to do that, it levied arbitrarily an assessment of $25 against each of its 140,000 members, in an effort to raise the biggest slush fund in American history, a lobby and propaganda fund of $3,500,000 that would make even Mark Hanna a little ashamed. Raising that money was not easy. Many doctors resented the assessment and the secret way in which it was levied. But the AMA brought terrific pressure on doctors individually, and on recalcitrant local societies, to force them into line. Senator Wayne Morse, of Oregon, has described in the Senate how one doctor, who protested the assessment, was punished, and along with him, many mothers and babies whose lives might have been saved by his skill and knowledge were punished.

But the reason I am going into this now is that the AMA millions are being spent for one of the shrewdest, one of the most calculating, and one of the most cold-blooded lobbying operations in American history, and a lobby which I cannot deny might have an effect on Congress if not exposed. So I want to do what I can now to expose it and to show Members of Congress how it is operating to make it appear as though the country is opposed to this legislation.

I can speak authoritatively on this subject because I have in my hand, and I will pass around to all of you, copies of the lobby program worked out by the high-pressure public relations firm hired by the AMA to do this job. It shows just how this lobby is operating to try to make it appear to Members of Congress that there is a grass-roots revolt against the President's health program.

When I called this "one of the shrewdest, one of the most calculating, and one of the most cold-blooded lobbying operations in American history," I was not exaggerating. I was basing that statement on the evidence. This evidence, from the files of the American Medical Association itself, shows that the doctors of this country are being asked to take advantage of their special, confidential relationship with their patients—including particularly Members of Congress—to lobby against what President Truman and many Members of Congress feel is a health program in the interests of the Nation.

Doctors enjoy a closer relationship with the average man than anyone else with the possible exception of the spiritual ministry. The average citizen in America looks to his doctors for guidance in the most important thing in his life, his health, not only because of his skill in medicine, but because he has learned that in most cases the doctor is a man of high character, integrity, and intellect. So this is a very close, intimate relationship, a very confidential relationship, that usually exists between doctor and patient. But I have evidence here indicating that the doctors are being asked by the AMA to capitalize on that relationship for the political purpose of defeating the President's health program and to retain the monopoly the AMA and the local medical societies hold over the economics of medicine.

This document which I request be inserted and made a part of the record at the termination of my testimony today, is the outline of the lobby and propaganda campaign presented to the conference of State medical societies in Chicago by the AMA's high-powered public relations firm of Whitaker & Baxter. Let me read to you, as a starter, a single paragraph of that lobby blueprint:

> **We need to locate the personal physician of every Congressman and every United States Senator** (the county society secretary probably should take on that job) and have him (the Congressman's doctor) **send a personal letter to his** patient, the Congressman, telling him of the danger of socialized medicine—

Let me say parenthetically, the reference is always made to socialized medicine, and not health insurance, and there is a distinct difference—

> and asking for his help in defeating any compulsory health insurance program which may be submitted.

Let me add that the words "personal physician of every Congressman and every United States Senator" in that sentence I have just read were printed in italics. But here is the pay-off on the way this confidential relationship between doctor and patient is being exploited by this propaganda and lobby machine. The paragraph continues:

> **We will provide form letters, but the society secretary should help the doctor.** if necessary, in rewriting and personalizing the letter in each instance. This letter also should ask for a reply—and again, the information in the replies **should be sent to the national campaign office and the AMA Washington office.**

That shows how this close personal relationship between doctor and patient is being exploited by an outside firm of commercial lobbyists and propagandists.

Now this campaign, may I remind you, the AMA has insisted in its alibis to rebellious members, is not a lobby campaign but an educational campaign. If this is so, then why is the Washington office to be kept informed of the correspondence with Members of Congress, the confidential correspondence between Members of Congress and their doctors?

This idea of using the doctors to influence their patients prevails throughout the AMA's lobby program. Each doctor is to be furnished with a color reproduction of the famous Fildes painting "The Doctor" to be posted in his office with several paragraphs of straight political propaganda and misrepresentation typed under this touching picture.

Now the AMA is not even kidding the doctors into thinking they are making this a great crusade for the benefit of the American people and for better medicine. In their proposal to post these pictures in doctors' offices they outline it as "the first step in making doctors compaigners in their own behalf." I might add that those words "in their own behalf" are also in italics. In other words, the doctors are being asked to use their personal, confidental relationships with patients to make a selfish political battle for their own benefit. Suppose the ministers of this Nation undertook such a campaign? What would be the public reaction?

The whole AMA campaign, as I have said, is based on using selfishly the trusting and confidential relationship existing between doctors and patients. Pamphlets are being printed, this campaign outline states, in lots of at least 7,500,000 each so that each doctor can have 50 copies for distribution to his patients. A "small, sparked-up human-interest folder" is being furnished "to satisfy the need among doctors for a simple piece that can be given to patients, mailed with statements or placed in waiting rooms."

To be sure that this propaganda gets to all doctors and through them to their patients, machinery has been set up in every State to see, as this document says:

> that shipments of materials from the national headquarter's offices actually get into doctors' offices and finally into the hands of doctors' patients.

Some of the material is not designed for distribution to the public. It is aimed at the doctors, to key them up to fight for the cause, and to show them confidentially how to do it. It contains "simple instructions on how to practice on the body politic," as this compaign outline expresses it. This means, in actual practice, the use of the "scare technique" popularized in Germany by Hitler. Patients are being told by their doctors to whom they feel they owe their lives that "if this socialized medicine legislation goes through I will quit my practice." A man who has relied on a certain doctor to carry him through a tough medical crisis is likely, after a hint of that kind, to rush to the mailbox with a letter to his Congressman opposing what the doctor has described as "socialized medicine." But the chances are that neither the doctor, nor the patient, could give even a rough approximation of the terms of the legislation.

In that connection I would like to make it perfectly clear to the committee at this time that I am opposed to socialized medicine as much as I am opposed to the strangling effect of commercialized medicine. Both are corrosive and detrimental to the people's welfare. On the other hand, health insurance, in the form which I am advocating and my colleague, a member of your committee, Mr. Biemiller, is advocating, is wholesome and desirable in leveling the hazards of health.

May I say here now, Mr. Chairman, in addition, that the difference between the plans proposed by the opponents which are predicated upon the Fishbein philosophy and that which has been proposed in the Congress, both in the Senate and in the House, is the difference between pure health insurance for the benefit of the insured and paid for by him and which guarantees that at a most critical time, when he is bereft of health, that he may hold his head high and pay for his illness, both to the doctor and to the hospital and everyone concerned with his recuperation, as opposed to the opposite theory of total dependence, despair, and becoming a pauper; or should I say a self-professed pauper, before he can get the benefit of the Taft-Fishbein bill, which is being backed by the opposition. In one instance, the patient can hold his head high and regain his health. In the other instance, he becomes totally dependent upon charity and is admitted with that understanding that he is penniless and hopeless.

That comes at a most critical time of a man's life, when he needs assistance and encouragement most.

Now, as I have stated previously, the difference is between health insurance and a bigger and more permanent system of pauperizing the needy. In the one instance, the insured and the employer pay a premium for which the insured gets all of the benefit. In the second instance, under the Fishbein philosophy, the man gets such assistance as he might get through the State, but only after he acknowledges that he is physically, financially, and they will see to it that he is, morally broken; that he has to make the confession that he is penniless and a pauper.

I want to emphasize that to the members of the committee, that in the instance of health insurance, you are getting what you pay for. There is nothing free about it, and, it covers those who pay the premium and their dependents. The other system covers an unfortunate and self-confessed pauper.

Some doctors are passing out cards to their patients to be signed and sent to Members of Congress protesting against this legislation. I have here in my hand, for example, a copy of a letter received recently by our colleague, Representative Dwight L. Rogers, of Florida. Mr. Rogers had sent to one of his constituents an acknowledgment of a protest against this health legislation. In reply the constituent wrote:

> I wish to state that this card was signed by me on what you might call pressure. At the time I signed this card my wife was in the hospital for an operation, and while at the doctor's office I was handed this card to sign, under the circumstances I felt that I was compelled to sign even though I am 100 percent for compulsory health insurance.
>
> It is my belief that thousands of other persons are handed these cards to sign under similar circumstances, and is very unfair to all parties concerned.
>
> It is requested that this card signed by me be stricken from your records or returned to me.

I hope the next time you members of the committee go through a batch of letters and cards opposing this legislation you will remember the incident I have just described to you. I am delighted to note that the Rules Committee has approved an investigation of lobbies. One of its first tasks should be an investigation of these high-pressure tactics by the doctors—tactics which I believe are a disgrace to the medical profession.

The high-powered personal approach of doctors to patients, which I have been describing to you, is just one of the tactics of organized medicine under the leadership of this public relations firm, which has taken the campaign out of the hands of the doctors, and turned the AMA into a professional political lobby instead of a scientific organization committed only to the public welfare.

This personal approach is retail lobbying. But the AMA lobby directors have worked out a scheme also for lobbying on a wholesale basis—to make it appear to Congress that whole communities are opposed to this legislation. This is done by railroading through every conceivable organization—whether of a political nature or not—resolutions opposing "socialized medicine."

Usually this is done by doctors or their wives who are members of such groups—and usually members of considerable standing. They arrange for a speaker to tell the club or civic organization, or professional group, without any regard for truth that socialized medicine as they label health insurance, would erect a huge bureaucracy, create new taxes, and break down the practice of medicine. Rarely is an opportunity provided for the organization to hear a speaker favoring the legislation. On the basis of this one-sided presentation endorsed by their respected colleague Dr. So-and-So, the organization rushes through a resolution opposing socialized medicine and sends it on to Members of Congress.

Specific directions are provided for getting resolutions adopted by organizations of all kinds, even those which have a policy of not taking action on public issues or which profess no interest in the issue. In order to get action out of such groups, form speeches geared to different types of audiences are prepared by the propaganda machine in Chicago. Detailed directions also are provided for getting these resolutions forwarded to Washington with "covering letters asking for a reply, in order to keep advised, if possible of the position of your legislative representatives." Once more, I remind you of the claim that this is an educational and not a lobbying campaign.

This lobby campaign plan, which I hold in my hand, outlines the detailed machinery for the operation of this false-front lobby for the doctors. It virtually dictates to every county medical society orders to adopt strong resolutions and even suggests what these resolutions should say. The presidents of these local societies are told to ask their Congressmen for replies, so that "his position can be made known to the doctors of his district." This document tells the doctors that the "combined political strength of all the doctors in a congressional district is impressive—and we need to put every Congressman on notice of the position taken by his doctor constituents." To counter this I hope the millions of average people will give their expression which will be even more impressive.

Now mind you, this is all part of the educational campaign—not lobbying campaign—as the AMA has described it to its members.

Speakers' committees are being organized in every county society to propagandize on this issue; and in some areas the doctors are even taking courses in public speaking so that they can spellbind their audiences with the propaganda written for them in the emotional fighting prose, which the press agents themselves said they would use. Form speeches are provided from the campaign headquarters in Chicago, but the publicity directors have urged the speakers to localize them to meet local conditions.

One of the most interesting angles of this so-called educational campaign is that it is aimed at presenting to the public only one side of the issue—the discussion is staged behind an iron curtain just as the Journal of the American Medical Association has done for many years. No medical journal has ever presented to the doctors a fair article by an advocate of the President's health program—quite contrary to the record of British and Canadian doctors. In line with that policy, this document warns the doctors against engaging in debates because they make a forum for the opposition. Obviously this is an issue on which the propaganda machine does not want both sides to be presented.

Campaign committees have been created in each State and in most counties to conduct this campaign. The instructions for the formation of these committees say that laymen may be added but warns that committees should be kept close knit and controlled by the profession's own chairman. Apparently organized medicine wants to control this campaign just as tightly as it controls the organization of medical practice.

Another interesting angle of this educational campaign is the approach to the press. The campaign directors have ordered that their words of emotional, fighting prose shall reach the people through normal newspaper and magazine channels, rather than through direct publicity releases. They propose to work with the great newspapers and the national magazines to get them to do special jobs, with real reader interest and assert that this work already is well started. Judging from the tone of some of the articles I have noted recently in the popular magazines I am afraid it is correctly stated—they have started.

And, may I add again at this point, Mr. Chairman, for your benefit, that there was a campaign once before, I believe, offering prizes for cartoons on this subject, and the prize was to be awarded only after the cartoons were published, so that they would have had the benefit of derision of a cartoonist, whether he received a prize for his effort of detracting from health insurance or not.

What Whitaker & Baxter mean by reaching the press through normal newspaper and magazine channels, rather than through direct publicity releases, I can only guess. But my guessing is influenced to some extent by what happened in a similar campaign conducted by this firm in California against Governor Earl Warren's proposal for a State health-insurance program. After that campaign was started the California doctors reported to the AMA that the newspapers had been cool and unreceptive to them at first but this attitude was changed by taking advertisements in every newspaper in the State. They reported naively that after the advertisements were inserted "we found that the response from editors in publicity has been far beyond anything we expected."

That was in California, Mr. Chairman. Let me say that there are some newspapers that are beyond any such inducement.

Their success in that campaign was what won for Whitaker & Baxter their present juicy contract with the AMA. We can assume that they will put their experience in California to good use in the national campaign, and any day now we may expect to see advertisements in the newspapers and magazines on the issue of national health insurance. In fact it was recently reported that the advertising is to be paid for by the local societies quite outside of the $3,500,000 campaign fund being raised by the AMA. So, unless there is a thorough lobby investigation by Congress, we may never know how many millions of dollars are being thrown into this special-interest fight by organized medicine.

On the other hand, most newspapers and magazines already are so friendly to the doctors' cause in their campaign against the Fair Deal program that organized medicine may decide the expenditure of money for advertising is unnecessary.

Mr. Chairman, before closing, I would like to say a word or two of explanation about this story I have been telling. No one has a higher regard than I have for most of the doctors who constitute the great medical profession. They have shown through the years their devotion to the public welfare by their widespread practice of charity medicine, by their research in the public interest, and by their high professional standards. But I want to distinguish between the doctors and what I called organized medicine—as represented by the hard core now in control of the AMA and many of the local medical societies. Organized medicine is controlled by "political doctors."

A study has shown that the house of delegates of the AMA is composed chiefly of specialists and high salaried urban physicians who are in no way representative of the bulk of hard-working doctors in the United States.

These political doctors are of a different character. They are engaging today in tactics which I am sure most doctors do not approve, and about which I am sure many doctors are deeply ashamed. The most dangerous part of this situation is that the political doctors are in complete control of the machinery of organized medicine. They are dictating its policies, and are using pressure as well as direct disciplinary action to enforce their will on the practicing physicians of this country. I know many doctors who favor national health insurance but are unwilling to risk retaliation from their medical societies by speaking out for it.

Mr. Chairman, I have had many interesting conferences and contacts with doctors all over the United States who have informed me of their feelings in this matter, and I am convinced that if there were a free expression on the subject that the great proportion of doctors would favor pure health insurance for the benefit of themselves as well as their patients.

Few doctors are in a position to buck their medical societies. In order to retain access to the hospitals of their community they must belong to the medical societies—and many of them are dependent for their run of patients upon other doctors. There is no way to tell how large a proportion of the medical profession would be in favor of this legislation if free thinking and free speech prevailed in medical circles today—but I am sure, after years of talking with doctors on the subject individually, that the number would be large.

This is a dangerous situation in a democracy, and I want every member of the committee to be fully cognizant of the situation. Here is a close-knit group of political doctors which borders upon a dictatorship in control of a vast propaganda machine and using every possible pressure to enforce their will on a great and humanitarian profession. The propaganda machine even writes the speeches and the letters for the doctors. I hope you will recognize when the so-called spokesmen for the AMA appear here that the statements they deliver are probably not their own—but statements written by the highly paid publicity firm of Whitaker & Baxter. The doctors are merely serving in this campaign as "Charlie McCarthys" for Whitaker & Baxter. The evidence I have presented proves this charge.

How many practising physicians they really speak for, no one can know. I cite again the case described by Senator Morse in the Senate—of a doctor on the faculty of Louisiana State University who dared to protest the AMA assessment along with almost 200 of the leading doctors in America. Soon after his protest was published he received the following letter from the State health officer of Arkanas relating to some lectures he had been asked to deliver in that State:

> This letter is being written to you as a result of a special request made by the Arkansas State Medical Society and the Pulaski County Medical Society, with reference to your appointment as special consultant in pediatrics for the Ar-

> kansas State Board of Health for the postgraduate pediatrics course to be conducted at the University of Arkansas School of Medicine in Little Rock during the period from March 10 to 12, inclusive, 1949.
>
> The Arkansas State Medical Society and the Pulaski Medical Society have been advised through authoritative sources that you were one of the 136 (later nearly 200) signers of certain papers and documents severely criticizing the American Medical Society. Through this action on your part the Arkansas State Medical Society and the Pulaski County Medical Society request that you not appear on the postgraduate pediatric course to be conducted on the above referred to dates.
>
> This department sincerely regrets that this most embarrassing situation has arisen and further regrets that it is necessary to cancel your appointment as special consultant for the Arkansas State Board of Health.

The doctor who received that letter—Dr. Myron E. Wegman—wrote to a friend as follows:

> While I am, of course, shocked that an expression of opinion on a controversial question before the profession and the public should be carried over to education and scientific work, I am afraid that it is not unexpected.

Mr. Chairman, that is a shocking commentary on the atmosphere prevailing today in the medical profession of this great democracy. But I am afraid the criticism is fully justified. May I add, Mr. Chairman, in closing, that the punishment in that case was not administered to Dr. Wegman so much as to the people of Arkansas, who need his advice on the saving of babies' lives—and to the people of America who, because of this incident, are less likely to get the real sentiment of the medical profession on this pending legislation. I hope you will remember that fact in assessing the testimony in these hearings.

Now, Mr. Chairman, that concludes my formal statement. I will be glad to answer any questions that any member may direct to me so far as I am able.

Mr. PRIEST. Mr. Dingell, the committee appreciates your appearance this morning and we are aware of the fact that it was a rather considerable strain on your physical condition to appear before the committee at this time.

Are there any questions, gentlemen?

Mr. SADOWSKI. Mr. Chairman.

Mr. PRIEST. Mr. Sadowski.

Mr. SADOWSKI. I would just like to compliment my colleague, Mr. Dingell, for the very fine statement he has made here this morning, and I might say that we all admire him for the fine crusade he has been waging in the interest of the Nation's health and bringing medical facilities to the people of the country.

I may say for myself and for the other members of the committee that we think very highly of you and the fine work you have been doing, Mr. Dingell.

Mr. DINGELL. Thank you.

Mr. O'HARA. Mr. Chairman.

Mr. PRIEST. Mr. O'Hara.

Mr. O'HARA. Mr. Dingell, I appreciate your statement has been consistent and that you have called our attention to the fact of the lobbying which is done by the AMA, and in that connection, do you know of any important legislation that comes before the Congress upon which lobbying is not done by one side or the other, or both sides?

Mr. DINGELL. Well, I know of no case where lobbying has reached the proportions of this campaign of the American Medical Association; not even the campaign to defeat the securities and exchange law which was handled, I believe, in this committee, when something like 800 or 900 thousand dollars was spent by the utilities, and when at that time they coined the words "death sentence," which has never affected adversely a single public-utility company worthy of the name.

In this instance they are proposing to spend more than 4½ times as much through the parent organization, and in addition to that, Mr. Chairman, that much will be raised by local societies, and they, too, have coined, Mr. O'Hara, a scurrilous and premeditated slanderous term, "socialized medicine," trying to defeat the principle, sound principles of insurance applied to the hazard of health by a scurrilous and contemptible reference, calling it "socialized medicine."

Now, we have repeatedly on the record in every instance told them that there is nothing intended; there is nothing provided for but health insurance, and I want to say now, if I may take time to elucidate, that if it is sound to apply the principles of insurance to fire and fidelity, to death, to crop insurance—hail, flood, drought; if it is sound to insure your life and to insure even your hogs and your cattle, as we have always insured them and even insure our bank accounts under the FDIC, that it is even more sound and desirable to insure against the hazard of health. That comes first. Without your health you cannot pay insurance premiums or anything else.

Now, if we are interested in insurance on hogs and cattle, how much more important is it for the family to be insured against the risks of health; and don't let anyone try to tell me that the people do not want health insurance, under which they will secure it by paying 1½ percent, because they do want it.

On a $50 a week earning, a man will pay 75 cents for health insurance to take care of himself, his wife, his children, and other dependents, if he has them, and they are unemployed.

Mr. O'Hara, Mr. Dingell, do you think this subcommittee or the Members of Congress generally would be intimidated or influenced against using their own best judgment upon any legislation?

Mr. DINGELL. I have absolute confidence that no such thing will happen, but I sound a tocsin of warning because I know how busy members of the committee are in their respective tasks and problems, and for that reason I point to this campaign. It is invidious, it is pernicious, it is the slickest thing that was ever conceived to befuddle the people and the Congress.

Mr. O'HARA. You referred to the "socialized medicine" adjective which has——

Mr. DINGELL. Slanderous.

Mr. O'HARA. Slanderous, of this bill.

Mr. DINGELL. Deliberately slanderous.

Mr. O'HARA. Now, what is the difference between this bill and the British socialized medicine?

Mr. DINGELL. Well, there is a great difference. Under our plan, so far as the Federal Government is concerned, we intend to merely collect the money and then to disseminate it to the States and the premiums will be paid for almost entirely by the insured; that is, the employee and the employer.

Mr. O'HARA. How much will be paid by each?

Mr. DINGELL. Well, we have not exactly made a decision on that at this point, but the general presumption, Mr. O'Hara, is that it would be 1½ percent upon the employee and 1½ percent upon the employer, or a total of 3 percent would carry the health insurance feature of this bill.

Now, the first six sections of this bill provide for other than health insurance. They are preliminary, you may say, they are a sort of foundation for the success of the entire plan, because we realize that we must build schools to train doctors; we must train nurses; we must train practical nurses; we shall have to build hospitals; we shall have to organize farmer cooperatives; we shall have to build hospitals in the hinterland—in the rural areas—and obviously that is perhaps the first step in the over-all solution of the deficiency in the Nation's health.

Mr. O'Hara. All of that is to be paid for by the Government?

Mr. Dingell. Well, that is pretty much a matter for the payment from the General Treasury, and it is pretty well covered in any number of bills on the House side and also on the Senate side. And, might I say to my good friend from Minnesota, Mr. O'Hara, there have been any number of bills presented heretofore which were nothing more nor less than pages out of the original Wagner-Murray-Dingell bills and some of the present bills again are parts from the Wagner-Murray-Dingell-Biemiller bills, or pages out of our present presentation to this committee like the Hill-Burton bill, for example, for construction of hospitals.

Mr. O'Hara. Would the payments apply only to those in relationship of employer and employee?

Mr. Dingell. I did not get that.

Mr. O'Hara. Would the payments required be only from those who had the relationship of employer and employee? I mean, what would happen to the group of people who are not in that category, who are self-employed, or who are not employed at all?

Mr. Dingell. Well, certain details, of course, regardless of what is in the bill, may have to be altered or worked out by the committee in final analysis.

Mr. O'Hara. The bill, as I understand it——

Mr. Dingell. But the bill, as it stands now, does not even provide for the tax feature, because if it did it would have been referred to the Committee on Ways and Means; but it does provide for revenues with which to give the benefits specified in the bill; and the presumption is that at a later date other committees will provide the revenue and the source of revenue which will be in the nature of a parallel tax or premium which, today, exists in the application to the old-age and survivors insurance; the very same principle. Every dollar paid in by the insured will be matched by a dollar paid by the employer.

Now, for those who may not be covered by that sort of a relationship, the States, counties, and cities, through their welfare agencies, will make a fixed contribution to the Federal Government to take care of those who are not employed. But may I say in that respect, Mr. O'Hara, there is no difference between the problem that is facing us today concerning the unemployed in connection with health insurance and that which faced us concerning the unemployed in connection with old-age and survivors insurance.

As you know, we have the OSI covering those who built up their own credits and receive their benefits as a matter of right. Then we have some who, at that time, were past the pensionable age who could not build up any credits in the set-up and these, of course, are receiving a gratuitous old-age pension, matched by the States, and which constitute quite a formidable number of recipients.

Mr. O'Hara. What would this phase of the bill raise in the way of revenue? Do you have any estimates on that?

Mr. Dingell. Well, Mr. O'Hara, there is some controversy on that, but my notion of it is it is a relatively easy thing to determine, and that is to estimate the earning capacity of those to be covered and assessed on a basis of 1½ percent; 1½ percent against the employer and 1½ percent to match against the employee; and I would imagine it would come anywhere from 4½ to possibly as high as from 4 to 5 billion dollars, but I am not a statistician and on that point I will have to forego that.

Mr. O'Hara. By that you mean per year?

Mr. Dingell. That is per year.

It is said by people who profess to know more about that phase of it than I claim to know, that it should not cost any more than is today being paid out for medical services. On that point I am a little bit skeptical, because I am allowing for that; but our objective is to make more and better medical services available to all, and as a consequence, the spread must be a little heavier, because it is going to be more widespread.

Millions of men and women who never see a doctor, after they are insured, undoubtedly are going to see their doctor. That is one of the difficulties, I understand, that they have been experiencing under the English system. Under the English system, men and women who were in need of false teeth, hearing aids, and glasses, who never had had any dental work done, who never were able to afford a hearing aid, and who at best went to 5 and 10 to purchase their glasses have rushed to the doctors; now, today, they are getting expert advice and expert care. That, of course, has rushed the British medical service, which by the way, is not as thorough or rather as complete, and the proportion of doctors is not as great as it is here in the United States. We in the United States are admittedly, even by the doctors, short of professional men to look after our people, and that will be more acute, I will say to my friend, unless we relieve that situation by training more young men and women for the medical profession, and in that connection there is a provision in the bill to stimulate production of doctors.

Mr. O'Hara. Mr. Dingell, I had some other questions, but under the rules of the committee, I am only entitled to 5 minutes.

Mr. Dingell. I am sorry. Perhaps I have occupied more time than I should have in answering your questions.

Mr. Biemiller. Mr. Chairman.

Mr. Priest. Mr. Biemiller.

Mr. Biemiller. Mr. Chairman, I would simply like to join my colleague on the committee, Representative Sadowski, in paying tribute to Representative Dingell for the contribution he has made during the past years in keeping the issue of a consistently sound health program before the people of the United States.

I have been very honored in being asked to join with Representative Dingell and various Senators in sponsoring the measure this year and I was very happy to have that honor paid me.

I also want to compliment Representative Dingell on giving an excellent presentation on what I think is one of the most high powered lobby campaigns the Congress has ever been up against and showing the people where a lot of the propaganda that is now current in the Nation is coming from. I think, furthermore, as these hearings go on, that it will be necessary to show that the same type of propaganda that is now being used against health insurance was used against workmen's compensation; against unemployment compensation; and against social security. The similarity of the campaigns—I am talking about the type of arguments used—is almost incredible. We will have exhibits for the record to show that the characteristic arguments that were used against other forms of social insurance are now being used against health insurance, and I think it will fall of its own weight before the public, just as did those arguments in those instances.

Mr. Dingell. I will say to my friend from Wisconsin, that I appreciate heartily his remarks and his opinion, but at the same time I want to say that not only are the presentations identical, but some of the opposition comes from the very same source.

Let it not be said here, Mr. Chairman, that the only opposition comes from organized doctors. The doctors—the hard core, let me say, not the doctors, the hard core of the AMA has been brought into this thing by a certain group of insurance organizations, supported by a certain element of employers who, in 1935, opposed for the very same reasons the instigation of the social-security program and who fought it so viciously, with pay roll, pay envelope campaigns in 1936. Let me say this to the members of the committee—of course, I do not believe they need any encouragement from me—but fear not any such thing as repercussions detrimental to your welfare on the score of health insurance. I have met that threat time and time again head on, and I will take on the hard core of the medical association and those who are whispering scandals into the dying ears of their patients, instead of administering to them, I will take them on in my stride and whip them to a frazzle as I have in every campaign. I did that repeatedly. I told them before the primary, "Now," I said, "you can do your worst to defeat me, and I serve notice on you now to try and take me out of circulation in the primary," and they failed.

Then I told them "to take me on now with your champ on the other side." And each 2 years I gained instead of lost in the proportion of my votes.

So, the rank and file of the American people, especially when they hear from their own average organizations instead of through this high-powered advertising firm and through the hard core of the AMA, as they have heard from the defunct National Physicians' Committee, that the great bulk of the people are for national health insurance and they will support any man who will stand up and fight for it.

Mr. Bennett. Mr. Chairman.

Mr. Priest. Mr. Bennett.

Mr. Bennett. Mr. Dingell, does your bill follow, so far as coverage is concerned, the pattern of the present social security coverage?

Mr. Dingell. Well; I will say to my friend from Michigan, that we have discussed the very fundamental of this bill at the White House before its provisions were circumscribed in words, and at that time, I expressed very definitely some of my own well thought-out opinions.

Mr. Bennett. Then you only cover a small segment of the so-called rank and file of the people under this bill?

Mr. DINGELL. Oh, no. We cover the great bulk of them. We will cover the great bulk of them.

Mr. BENNETT. How many people?

Mr. DINGELL. I would imagine we cover about 80 percent of the people of this Nation.

Mr. BIEMILLER. Will the gentleman yield? I think that I can clear that point up with just a brief statement.

Mr. BENNETT. Yes.

Mr. BIEMILLER. I think that the point that you are making, and probably Representative Dingell perhaps misunderstood you, is that the bill provides coverage identical with the extended coverage that is suggested in the bill that is now pending before the Ways and Means Committee on Social Security.

Mr. BENNETT. I was asking about this bill.

Mr. BIEMILLER. That is in this bill. This bill does make that provision. It includes those who are now covered or to whom coverage would be extended to under the social-security legislation now pending before the Ways and Means Committee.

Mr. DINGELL. It is parallel.

Mr. BENNETT. Who else is covered; what other groups? Does it cover, for example, State and municipal employees?

Mr. DINGELL. Well, they can come in. They can come in under the plan, and I know of their clamor now for getting in under the OSI. They are going to insist on being covered if they are not already specifically covered, which I think they are; but it will have to be on a sort of an agreed basis, because the Federal Government is not going to coerce them to come in.

Mr. BENNETT. I want to clear up a point Mr. O'Hara raised of persons who are self-employed. Is there any group which is self-employed which is eligible to come in under the provisions of this bill?

Mr. DINGELL. We are trying to work that out now with the Ways and Means Committee to cover that under the OSI. That is for annuities, and, if that is worked out, farmers can come in as self-employed; small-business men can come in as self-employed; and under this bill they could come in as self-employed, and I am sure they will want to come in as self-employed for the purpose of health-insurance coverage.

Mr. PRIEST. The Chair regrets that it will be necessary to adjourn at this time, as there is a quorum call on the floor of the House.

The committee will stand adjourned——

Mr. DINGELL. Mr. Chairman, I just want to say that I will be glad to appear and answer any other questions that any of the members of the committee may desire to ask at any time that you deem proper.

(The document mentioned earlier by Mr. Dingell is as follows:)

[From the Dallas Medical Journal, April 1949]

WHAT WILL WE DO WITH THE DOCTOR'S $25?

THE NATIONAL CAMPAIGN PLAN OF PROCEDURE

(Presented by Clem Whitaker, Leone Baxter, directors of the national education campaign of the American Medical Association, for the Conference of State Medical Societies, Chicago, February 12, 1949)

Mr. Chairman and ladies and gentlemen; every minister preaches from a text—and every campaign, if it is a successful campaign, has to have a theme!

The theme, if it is geared to reach more than 100 million people, as we must in this campaign, should have simplicity and clarity.

Most of all, it must high-point the major issues of the campaign with great brevity—in language that paints a picture understandable to people in all circumstances.

EVERY DOCTOR A CAMPAIGNER

That's one of the reasons we have a large blown-up color reproduction of the famous Fildes painting, The Doctor, an exhibit here today, with the simple caption under it: "Keep politics out of this picture!"

The picture and the caption, even without elaboration, focus attention on one of the most important arguments against government-controlled medicine.

Smaller color reproducions of this famous painting soon will go up in doctor's offices all over America as one of the first steps in dramatizing our case to the American people—and more important—as the first step in making doctors campaigners in their own behalf. For this purpose we have added a hundred words of text which help to establish the theme of this campaign.

I'm going to read you that text, because it stresses, in simple language, the essential points of the case which we believe will turn the tide against compulsion and in favor of voluntary health insurance.

The text is as follows:

Keep Politics Out Of This Picture

When the life—or health—of a loved one is at stake, hope lies in the devoted service of your doctor.

Would you change this picture?

Compulsory health insurance is political medicine.

It would bring a third party—a politician—between you and your doctor. It would bind up your family's health in red tape. It would result in heavy payroll taxes--and inferior medical care for you and your family. Don't let that happen here.

You have a right to prepaid medical care—of your own choice. Ask your doctor, or your insurance man, about budget-basis health protection.

This is signed: American Medical Association.

These smaller posters will be sent under the signature of the AMA to show medical men throughout the country that the association is resolutely behind the national campaign. They will be sent to doctors only at their own request. Return postal cards will be in the mail shortly.

The dimensions of the posters are approximately 18 by 20 inches. They are dignified—but carry a strong message—stronger, we are aware, than most doctors are accustomed to display in their waiting rooms. Their final cost, including the right to reprint the famous picture, art work, stock, printing and mailing comes to about 30 cents each. If we can light the crusading fires, and tie into the campaign the majority of the doctors of this country, for the cost of 30 cents each, the results will be well worth the price.

For the information of some of you who are wondering just when these will begin to show up in doctors' offices—here is the production schedule: This poster has been in the works for 3 weeks. It was out of our hands on February 7. The press proofs will be submitted to us on March 3. The schedule calls for delivery to the bindery on March 15; cut and drill sheets, March 21; production completed March 25; inserting, addressing and mailing completed on April 4.

That's a lot of time—60 days; a lot of effort; a lot of money. And we look for real results.

THE REAL AMMUNITION

The major portion of the campaign budget will be spent for production of materials—the campaign ammunition. We are not going to waste any campaign funds on faulty ammunition. Any general pamphlet produced will have to be printed in minimum lots of 7,500,000—just to put 50 copies into each doctor's hands alone. To make the smallest trickle beyond that outlet to the public, we shall have to print a minimum of 10,000,000 copies of any piece produced. That means simply that we can't afford to experiment. We can't afford to throw our next-best or divided efforts into print and hope it will suffice. What we produce must be brief enough to read—dramatic enough to create sentiment—and sound enough to produce action from the thinking people of this Nation.

Some very excellent basic material has been produced by men of medicine and men close to the profession, long before the national education campaign was initiated—and that will give the production of the new material the most helpful impetus.

One of the pamphlets in the planning and production stage is a small, sparked-up human-interest folder to satisfy the need among doctors for a simple piece that can be given to patients, mailed with statements or placed in waiting rooms. It will be suitable as well for general use by allied professions and industries. This will be a special appeal, illustrated public pamphlet, geared to the interests of the average citizen—the veteran, farmer, mother, businessman, wage-earner, etc.

The doctors will receive their first copy of that pamphlet direct from AMA headquarters, with a brief letter, telling some of the high lights of the proposed campaign, and advising the doctors that they can get the pamphlet in quantity through their State or county medical societies.

A question-and-answer pamphlet which actually will serve as the doctor's campaign handbook, also is in process. The handbook should give every doctor, not only the facts he needs to argue his case effectively, but also simple instructions on how to practice on the body politic.

The small leaflet will be a general public piece and can be distributed through many channels. The handbook, while beamed to doctors, also will be used for distribution among members of our lay committees. We believe that the dentists' associations, the druggists' organizations, the hospital associations, the medical auxiliaries and various other closely related groups should be urged to turn out similar material or use ours under their own imprints.

We also plan to assist many cooperating national organizations—veterans' groups, for example—to produce pamphlets slanted to their own memberships, and emphasizing the arguments which will have special appeal to them.

A third pamphlet is in preparation whose title will be "Calling Every Doctor—This is an Emergency!" This too, will go directly to physicians, with a letter from the American Medical Assocociation. It will be a briefly presented statement of the issue, the objectives—and the procedure to accomplish those objectives. Its purpose will be similar to that of the poster—to get every doctor who believes in the private practice of medicine working enthusiastically with his local campaign committee.

A PAMPHLET CAMPAIGN

Actually, this issue is made to order for pamphlet presentation, and we plan heavy use of pamphlets, running into many millions of copies, to tell medicine's story dramatically and effectively to both leaders of public opinion and rank-and-file citizens throughout the country.

With new developments and changing conditions in the campaign, there likely will be need for frequent revision of the text of early pamphlets, or the production of entirely new material. As a consequence, a heavy load will fall on our writing and production department and one of the first problems of course is to produce copy fast enough to satisfy the press, AMA members, State and county societies and the literally hundreds of business and civic groups which all require special servicing.

Above all, the written material in this campaign must be emotional, fighting prose. We can't win an audience with dry, statistical copy. We have to give the people facts, but in very readable form. The surest way to break down apathy and public disinterest is to turn out copy that stirs the emotions—and in doing so, opens closed minds.

It is vital, too, that much of this flow of words should reach the people through normal newspaper and magazine channels, rather than through direct publicity releases. We intend to work with the great newspapers and the national magazines to get them to do special jobs, with real reader interest, and that work already is well started. The story of British medical practice today, as an example, is actually one of the most important stories of this era. AMA already has started the wheels moving to get the truth and publicize it before this campaign began. It is a story which must be told and retold by staff writers of American magazines and newspapers.

Once it has been printed in a magazine or newspaper of national importance, reprints of the article will be placed in the hands of key people throughout the country.

ORGANIZATION PHASES OF THE CAMPAIGN

There are two distinct phases of organization activity planned.

First is the plan of organization and operation for medical groups, which involves the relationship of the State and county societies to the AMA in the conduct of the campaign. This calls for a definite division of work, with fixed responsibility in each area, so that a vigorous grass-roots campaign can be developed.

Second is the plan for mobilizing the strength of the major public organizations, local, State, and national—groups like the farm organizations, the more powerful business and civic associations, fraternal, religious, and veterans' organizations.

The program with respect to the medical organization structure has been discussed carefully with the campaign coordinating committee members in order to reach practical and intelligent decisions. The job must be done with as little friction as possible, so that doctors in the field will be directing their energies to winning converts, and their fire to the opposition. It is usually difficult to get 150,000 individualists (and most doctors are individualists) to agree on anything, but if ever the members of the medical profession needed to pull together, this is the time.

STATE MEETINGS

A number of States have reported that within the next 30 to 60 days after the national meeting of State representatives (February 12 in Chicago), they are calling meetings of county society representatives in their own States, for the purpose of passing along to them the national plan of campaign, and determining on their own procedures in relation to it.

Accordingly, for their help and guidance at this time, we will chart some of the important work which needs to be done within the States.

COUNTY SOCIETY ACTION

1. Every county medical society in the United States should adopt a strong resolution against compulsory health insurance within the next 60 days—and should then direct the president of the society to communicate its action, by letter or telegram, to the Congressman (or Congressmen) representing the district; also to the State's two United States Senators. The society"s resolution should emphasize the inevitable deterioration of medical care and the danger to the public health, once government medicine is in operation, and should stress the tremendous growth of the voluntary systems and that the American people are taking care of the problem in the American way. The president's letter to the Congressman or Senator should ask for a reply, so that his position can be made known to the doctors of his district. Copies of all replies should be forwarded to the national campaign offices and to the Washington office of AMA as rapidly as they are received. We will provide several form resolutions as a guide to the societies.

The combined political strength of all the doctors in a congressional district is impressive—and we need to put every Congressman on notice of the position taken by his doctor constituents.

LAWMAKER'S DOCTORS

2. We need to locate the personal physician of every Congressman and every United States Senator (the county society secretary probably should take on that job) and have him send a personal letter to his patient, the Congressman, telling him of the danger of socialized medicine, and asking for his help in defeating any compulsory health insurance program which may be submitted. We will provide form letters, but the society secretary should help the doctor, if necessary, in rewriting and personalizing the letter in each instance. This letter also should ask for a reply—and again, the information in the replies should be sent to the national campaign office and the AMA Washington office.

SPEAKERS' BUREAUS

3. We need an active speakers' committee in every county society to cover local meetings. The executive secretary of each of the State societies should aid in organizing this work. We will provide form speeches, but in many cases they will need to be localized to meet local conditions.

One of the very great requirements is for every State to develop top-bracket speakers both in the profession and apart from it, who can be called on for important meetings, both State and national.

DEBATES

We do not believe it a sound campaign practice to sponsor too many debates. They make a forum for the opposition which would be difficult for them to secure otherwise, and they are too easily stacked. This is particularly true of broadcasts of debates open to the public. Our speakers will stick to the facts. But already in this campaign, the opposition has begun to use the facts very loosely. Their claques in the audience are briefed to applaud wildly every trick phrase their speaker utters. And the public has no way of knowing which is fact and which is fancy. If our case were so poor that we had to stack meetings, it would not be worth the effort we shall all put into this campaign.

PRESS COMMITTEE

4. We need a press committee in every county society to make personal calls on the editors of all newspapers in the county and urge their support of medicine's position. This work, again, should be coordinated by the State society.

ENDORSEMENT DRIVE

5. Since our first objective is making the postion of the people on this issue known and recognized by our representatives in Congress, much of our first campaign effort must continue to be devoted to getting organizations on record in opposition to compulsory health insurance.

In this connection, one of the first mailings from the national campaign headquarters to the States will be a list of conventions scheduled in each State during 1949. This should reach you during the coming week. This is not to be considered a complete list, but we sincerely hope it will be helpful in beginning the drive for resolutions in your area. It will include all conventions reported at this early time; you will need to add to it as others are scheduled. The list will contain the following information:

Name of organization.
Town where convention is scheduled.
Estimated attendance.
Person to contact, to our best knowledge.
Whether convention is national, State, or local.

Some organizations on the list may have a policy of not taking action on public issues, or will profess "no interest." When an issue is of fundamental importance, as ours is, however, and when somebody takes the time to explain the honest facts and drive for a resolution, virtually all the important organizations do take action.

As fast as they are produced, form speeches geared to different types of audiences will come along to you; also suggested form resolutions which can be localized or particularized as you see fit; also the question-and-answer pamphlet providing brief, factual answers to the most commonly asked questions concerning the issue of compulsory health insurance. Armed with this material, a good speaker will have little trouble making a splendid, positive case before even a difficult group.

ENDORSEMENTS PROCEDURE

Since the value of formal action from any group is in exact proportion to the work done to capitalize on it, these are some of the things which must be done, once a good resolution is in your hands:

If it is from a strong, State-wide organization you should send copies of the resolution first thing to:

Your two United States Senators.
Your Congressmen.
Your State legislators.
The AMA office at 1302 Eighteenth Street NW., Washington, D. C.
The National Campaign Headquarters, 1 North La Salle, Chicago.

Every county medical society, immediately it has acted, should send copies of its resolution to:

Its two United States Senators.
Congressman from its own district.
State legislators from its own district.
Its State campaign chairman at the State medical association office.
The AMA office at 1302 Eighteenth Street NW., Washington, D. C.

The National Campaign Headquarters, 1 North La Salle, Chicago.

Action of other county or city organizations should be reported to United States Senators only when deemed of sufficient importance to merit such handling but should be reported at once to all others listed above.

Resolutions sent to all Congressmen should be accompanied by covering letters asking for a reply, in order to keep advised, if possible, of the position of your legislative representatives.

Originals of all resolutions should be kept in the originating office, unless otherwise requested.

Copies of resolutions should reach the press and radio on the same day action is taken if possible, through your State or county publicity channels, as determined by your campaign chairman.

When an organization has acted, it should really be asked to go to work in the campaign:

(*a*) Getting literature to its memberships, either through meetings or by use of its mailing list or both.

(*b*) Using its house organ or news letter for both news and editorials on the issue of compulsory health insurance.

(*c*) Offering its talented members as volunteer speakers on the issue of compulsory health insurance.

(*d*) (Members on record in one organization can help, too, in presenting resolutions to other organizations of which they are members, and helping to steer them to favorable conclusions.)

Most of the State medical associations have working organizations long in existence and thoroughly ready and able to handle their part in the campaign.

6. Machinery will have to be set up in the few States where it is not already operating, probably under the direction of the State society office, to see that shipments of materials from the national headquarters actually get into doctors' offices and finally into the hands of doctors' patients.

NAME YOUR STATE CONTACT WITH NATIONAL HEADQUARTERS

It is important to name the person, presumably in your State association office, to whom the national headquarters will channel supplies of literature and other materials for fast distribution in your State. His name, address, and telephone number should be sent at once to the national campaign headquarters.

In some States it may be desired that supplies go direct to the county society offices. However, it is the feeling of the national campaign directors that campaign materials in general should channel through the State medical association machinery, and down to the county societies under the directives of the State itself. That, we believe, should be determined within each State.

AUXILIARIES ARE EFFECTIVE

Obviously, the women's auxiliaries of the medical societies will be able to carry a big share of the load. As some of the California representatives will tell you in that State's campaign on the issue of compulsory health insurance, the women accomplished some of the most effective work done in speaking before women's organizations, in literature distribution, in securing endorsements, and in keeping the club and women's editors enthusiastic on the issue.

COMMITTEES

It is important within the States to organize committees of doctors, both on the State and the county basis, who are able to give their time to the campaign objectives, to handling speaking engagements, and to working on endorsements.

Laymen may be added to committees as time goes along, as the work gets heavier, and as laymen become more interested in the issue. (Committees should be kept close-knit, however, and controlled by the profession's own chairman.) In any case, help from leaders outside the medical profession should be sought and welcomed. Not only will such aid lighten the load on doctors, but it will help build the broad public picture of the danger in socialized medicine to every other element of our national life.

CONCLUSION

We recognize that AMA's permanent staff, headed by Dr. Lull, has a full load of work in just maintaining its normal activities. We will need a tremendous amount of help from them, however, and we have had many warm assurances of their desire to be in the front lines of the battle, as they have been for years past.

We visualize that they will serve in many capacities, giving the national campaign the aid of their counsel and guidance, as required, providing the background material and the knowledge of the vast medical organization which we so badly need, flying into key States to carry the message to Garcia, maintaining lines of communication with all the State and county societies, opening doors everywhere that are vital to the success of medicine's campaign.

The public relations department of the AMA, under the very capable hands of Larry Rember and his staff, is going to have a tremendous task to perform. Its work will be vastly heavier as a direct result of the campaign. The States, incidentally, probably will see more of Mr. Rember, Mr. Bach, and Mr. Doscher than ever in the past, for part of their work will be trouble shooting in areas where the campaign at one time or another may bog down and require a jet-propulsion assist.

Their work will coordinate closely with the national campaign and in many respects will overlap it.

They will make an intensified, affirmative campaign to drive home to the public the vital part the medical profession plays in the lives and the health of Americans. They will intensify their efforts to interpret factually—and dramatically—the work of the departments of the AMA—work that daily reflects highest credit on the profession and which has made the entire world deeply respectful of the AMA.

We are confident, gentlemen, that the campaign which has been laid out is a practical, workable, effective campaign, and will produce the results we must have. We are confident that working together, the fight against Government-controlled medicine can be won, and that, when it is over, medicine will have pointed the way for the whole Nation, at a time when the Nation might easily travel either road—toward a controlled economy or toward a free economy.

We sincerely believe that the individual doctors throughout the Nation, who have paid $25 each to tell their story to America, will feel proud, as the story unfolds toward its conclusion—proud of their part in writing one of the greatest and most significant sagas of American history.

Mr. Priest. Mr. Dingell, Mr. Wilson may have some questions and other members of the committee may have some questions, and we may ask you to return.

The prepared statement of Hon. J. Donald Kingsley, Assistant Administrator, Federal Security Agency, having been released through prior action of the Agency, is made a part of the record at this point. Mr. Kingsley will appear at a later date for summarization of his statement and any questioning by the subcommittee members.

(The statement is as follows:)

Statement by J. Donald Kingsley, Acting Federal Security Administrator

Mr. Chairman and members of the subcommittee, Mr. Oscar Ewing, Administrator of the Federal Security Agency, was anxious to be here today for these hearings on President Truman's health program—the first ever held, incidentally by a House committee on national health insurance. But, as you know, he has been through a serious operation and is not yet well enough to appear. I am, therefore, appearing as Acting Federal Security Administrator to present the Administration's viewpoint on this important legislation.

My understanding is that the committe is now opening general hearings on the President's health proposals, and related measures, and will study the detailed proposals in later hearings. In accordance with that plan, I will not discuss provisions of the bill from a technical standpoint, but will leave that for later witnesses as the bill is taken up title by title. Today I would like to discuss the over-all basis of these proposals and the reasons they are being advanced by the administration at this time.

I would like to begin by quoting briefly from President Truman's special message to Congress of April 22, 1949. In that massage he said:

"Now that we have the medical knowledge that can bring good health within our reach to a degree heretofore undreamed of, we must improve the means of putting that knowledge to practical use. Good health is the foundation of a Nation's strength. It is also the foundation upon which a better standard of living can be built for individuals. To see that our people actually enjoy the good health that medical science knows how to provide is one of the great challenges to our democracy.

"Our objective must be twofold: to make available enough medical services to go around, and to see that everybody has a chance to obtain those services. We cannot attain one part of that objective unless we attain the other as well."

That is the philosophy behind this program—a many-sided program designed to meet the porblems pointed out last year by the National Health Assembly. That meeting, you may recall, brought together the Nation's leading authorities, both professional and lay, on the subject of national health. Out of it came a number of unanimous recommendations, approved by every interested group from the American Medical Association to the CIO.

The only really controversial proposal in the administration's seven-part program, which is before you in the bills introduced by Representatives Dingell and Biemiller, is the proposal for national health insurance. The other titles are approved, at least in principle, by all authorities, including the AMA.

Some of you, I know, are disturbed by the size and scope of this 163 page legislative plan, feeling that it tries to encompass too much, at least for one bite. You feel that some parts of this program, the less controversial parts, might be passed now, but that the disputed sections, at least the one dealing with national health insurance, should be drastically modified, or put aside in toto for later consideration.

I would like at the outset to challenge that suggestion. This program is a carefully worked out, integrated plan, for meeting the Nation's health problems, problems which I do not believe it is an exaggeration to say are serious threats to our national well-being and our national defense. The less controversial proposals are important and of equal value, perhaps, with the disputed portions of the bill; but without the whole they will prove ultimately ineffective in meeting the basic health problems which we face.

Those problems, as the President has suggested, are of two kinds—the problem of providing sufficient medical personnel and medical facilities to meet the Nation's needs, and the problem of making that medical care available to all the people of this great Nation.

"But why all this fuss?" some people say. "Aren't we the healthiest Nation in the world? What's the emergency? Why all the hurry?" Those are basic questions, which warrant an answer.

There is no doubt that American medicine is of the finest quality. We have perhaps the world's best trained corps of doctors and certainly the world's most plentiful supply, measured on a per capita basis. We are one of the healthiest nations in the world. But that does not mean we are as healthy as we can be, or should be, and it does not mean there is no room for improvement. Our medical statistics, and our personal day-to-day experience, show there is tremendous room and tremendous need for improvement. I do not need to labor that point; but let me point out a few evidences of that fact.

Perhaps the most startling evidence developed during the recent war when we found that one out of every three of our young men summoned for military service was physically or mentally unfit to fight for his country. These were not old men, but young men in the prime of life. This rejection rate shocked the entire country.

I am aware, of course, that there has been controversy over the selective-service figures. Some apologists for the medical status quo argue that the standards of our military services were very high and that many of the rejected boys would have been accepted by some other armies. That is unquestionably true. But American standards are higher than those of most other countries, and I hope they will continue to be, in peace, as well as in war. Again, it is argued by some people that many of the defects for which these men were rejected could not have been corrected with the best of medical care. That, too, is true, but it does not make up for the fact that thousands of those defects were curable, and many of the others might have been averted by proper care in childhood. I would like to call your attention to a study made in North Carolina, showing that the rejection rate among children raised in orphan asylums where medical care was available was far lower than among the supposedly more favored children who lived with their families.

I could cite many more evidences of this kind—that the quantity, if not the quality, of our medical care is far short of what it should be. I could go on at some length, quoting statistics to show that our death rates for mothers and babies in childbirth are higher than in some other countries, and vary sharply from area to area in this country, which means that in some areas far more mothers and babies are dying than is necessary. I will quote just one set of such statistics. In New York only 1 mother dies in childbirth per 1,000 live births. In Mississippi the rate is three times as high. In that State, and in others, the death rate is higher for mothers in childbirth than in most modern nations.

That is a shameful report to have to make on the state of health in the world's richest country. It is a report I hope will not have to be made to many future Congresses. But that report is based on facts we cannot escape. It is facts like those that create the emergency. It is facts like those that create the need for haste. Every day we delay, costs the lives of more mothers and babies, creates more chronic disabilities that might have been avoided, and permits unnecessary tragedy to wreck more families—quite aside from all the personal and national economic costs involved.

It was facts like those that brought from last year's National Health Assembly recommendations which have been embodied in the comprehensive health program now before you—a program recommended in its essentials by President Truman as long ago as November 1945. The National Health Assembly studied the evidence and found that this great Nation not only lacked the medical personnel and the medical facilities it needs, but lacked a means of getting the medical care now available to millions of people who most needed it.

The fact is that while our medicine has made striking gains as measured in terms of life expectancy and other indices of medical progress, our progress has been ragged and uneven. And our basic problem is not medicine, but the economics of medicine, the oxcart ways in which we finance our medical services. Because of these antiquated methods we do not have enough doctors or hospitals, enough dentists or nurses. And those we do have are inequitably distributed geographically, and available only to the relatively rich or to the charity poor.

We do not have enough doctors and hospitals because, at present, we have no way to support them. Under our private-enterprise system, supply tends always to meet effective demand. If we had effective demand for medical care, which means demand backed up by purchasing power, we would soon have the doctors and the hospitals we need. The fact that we are desperately short of both proves that the people do not have the purchasing power to get the medical care they need. That is the basic truth back of this rounded health program. There is little use in training large numbers of doctors, or building many more hospitals without at the same time providing means through which the people can pay to use them. We have too few doctors and too few hospitals at present in large part because substantially larger numbers could not be supported under present methods of paying for medical care.

Moreover, we have a poor geographic distribution of our medical personnel and our medical facilities for the same reason. The distribution of doctors, dentists, nurses, clinics, and hospitals follows the general pattern of income distribution in the country. The wealthier communities and States have far more than their per capita share of the available supply while the poorer ones have far less.

If you live in New York State, for example, with a per capita annual income of more than $1,600 you will find available 5 hospital beds for each 1,000 of population and 1 doctor for every 500 persons. But if you live in Mississippi with a per capita income of only about $600, you will find less than 2 hospital beds per 1,000 of population and only 1 doctor for every 1,500 people, instead of 1 doctor for each 500.

Comparable contrasts are usual today, as between sections of the country, as between States, and as between counties within States. The wealthier and urban sections have far more medical personnel than the poorer or the rural areas.

It this because people with higher incomes have greater health needs? Obviously not. All statistics prove just the contrary. Is the concentration of medical facilities in the Northeast or in urban areas as compared with rural areas a reflection of more serious medical problems in those areas? Demonstrably not. One of the disturbing facts about the draft rejections was the high proportion of them among youths from rural areas. Our poor distribution of medical facilities, geographically, is due to the fact that doctors naturally settle in communities where they can make a living and hospitals are built only in the places where they can be financed.

Perhaps the most striking example of this geographical maldistribution of medical care is found in connection with pediatrics. Only 4 percent of our qualified pediatricians are located in areas of the country where more than 60 percent of our children live. The pediatricians are in one spot, where there is money, but few children. Our children live in another spot where there is relatively less money, and therefore few specialists on child care.

A third universal problem in connection with the distribution of medical care cuts across geographic lines and follows instead the pattern of family income. It is frequently said, and there is great truth in the statement, that only the rich and the very poor in this country get the best available medical care. The rich can individually afford it, the community provides it for the very poor. The great bulk of the American people are caught in the middle. They do not have the wealth necessary to assure adequate medical care in an emergency. And they are too well-off and too self-reliant to accept charity.

As a result, even if you live in New York City with all of its doctors and its unexcelled hospitals, the chances are that you do not get the kind of medical care you need. The costs of modern medical and hospital care are too high for most people under a system in which the whole cost falls upon the sick and is wholly unpredictable for the individual. As an individual you cannot, unless you are relatively wealthy, be sure you have set aside enough to take care of medical emergencies. Unexpected illness can consume your life savings and plunge your family onto charity or into hopeless debt almost overnight. We all know cases of this kind. Only recently, as a dramatic example, a family in Louisville was called upon to provide medicines costing $60 a day to keep the mother of the family alive. It was a middle-income family which had always been self-supporting and self-respecting, but overnight it was thrown onto charity, with all that means in social loss to the family and the community. This case happened to be dramatic enough to attract the attention and the support of the community. In thousands of less dramatic cases every year, the result is unnecessary tragedy and death.

These, then, are a few of the reasons why President Truman has asked Congress to act "without further delay" on his broad national health program.

The President's program involves seven parts. About six of them there is little controversy—except over details. I would like to take them up briefly before getting into the more controversial subject of national health insurance.

The President's program proposes to institute a Nation-wide recruitment and training program for doctors, dentists, nurses, sanitary engineers, and other medical personnel, so that by 1960 our medical manpower will be 40 to 50 percent above today—and so that we can have a closer approximation of equality of distribution between rural and urban areas. To do this, we must start at once to build new medical colleges, expand the facilities of present ones, and establish scholarships which will enable qualified young men and women to undertake the long and expensive training regardless of their financial circumstances.

The plan proposes also, during the next 10 years, to increase the number of hospital beds by at least 65 percent—the maximum goal we can hope to achieve, although our need is even greater. In reaching this goal we should, as the pending bill proposes to do, provide special aid for constructing hospitals in the rural areas and small communities where they are most desperately needed.

This program contemplates the establishment of an integrated hospital system, with a series of hospitals in every State that will include every kind of hospital facility from the local diagnostic clinic up to a modern fully equipped medical center, staffed by specialists in every field of medicine. This will serve to make available complete diagnostic facilities to every doctor, one of our most urgent needs, no matter how small the community in which he lives. It will establish a system of referral for patients which will give, let us say, a farmer living in an isolated rural district prompt access, in case of need, to the most highly specialized treatment.

The next step in this program of modernizing our medical care would extend our public health services to the 25 percent of our population, chiefly in rural areas, which do not now have even a full-time health officer, and would staff fully all public health departments and house them in modern public health centers. In the small towns and rural districts especially, this program proposes to equip these centers with X-rays and all the other modern diagnostic facilities which the average physician cannot himself afford to purchase.

This plan, which you are considering today, proposes also to provide rehabilitation service for all the 250,000 men and women in civilian life who each year become disabled through illness or injury. The plan, furthermore, would extend as rapidly as possible our maternal and child-health services and various child welfare services in order to reach the millions of mothers and children who are still cut off from these benefits.

As quickly as we can train the necessary medical and related scientific personnel, the program purposes to double or triple the amount of Federal aid for medical and related research. The program proposes to delve more deeply into such growing menaces as cancer and diseases of the heart, which every year are costing more lives, and into the causes of chronic invalidism which is taking a terrifice annual toll in personal tragedy and cost to the community.

This program purposes to focus more and more attention on mental health, promote research in the field of psychiatry, and in the mental-emotional aspects of physical illness, and to expand manpower and facilities for both preventive and curative work in this field of steadily growing importance. Finally, the program proposes to promote dental research and expand the facilities of the schools and public health services in caring for the teeth of our children.

There is little opposition to this program I have just outlined. Nearly eveyone acknowledges the need for these moves, and the desirability of acting on them. The only real, basic, controversy in this entire program involves the problem which is attached in the seventh and last title of this bill, the title dealing with national health insurance.

This is what the President has rightly called "the heart" of the whole program. Because without an effective system for buying medical care, the American people will not get it regardless of the number of doctors or hospitals we have—unless that care is then provided for them by the Government.

Objections to national health insurance do not seem to be directed at the objective of title VII. The need for a better distribution of medical care is conceded even by most of those who oppose this section. What they object to is the method proposed, a method which they call socialistic, which they say would create a huge bureaucracy, cost billions of dollars, and would lower the standards of medical care.

This Administration is not offering a plan for socialized medicine. It does not want socialized medicine. It is, in fact, offering national health insurance as the only safe and certain way to avoid socialized medicine.

Under the President's program doctors would remain in private practice. Hospitals would remain under private ownership and control. No doctor, no hospital would come under the plan except by his own or its own free will. The Government would neither own nor control the practice of medicine. This is a proposal for social insurance and there is much evidence to indicate that an adequate system of social insurance is one of the surest way to avoid socialism.

The British hospitals provide an example. These have recently been taken over by the government and are operated by the government. That conforms with the definition of socialism. But it is quite possible, I might say even likely, that the British hospitals would be under private, voluntary control today if the British Government had provided a comprehensive and effective system of national health insurance in 1911, instead of falling back on half-way compromises somewhat similar in scope to the proposals now bein offered in this country as a means of avoiding what is incorrectly terms "socialized medicine." Had the British Government at that time, or at any time before the second World War taken really effective steps to provide an orderly system of payment for hospital services, the story might have been far different. I think the same moral holds for medical services provided by physicians.

The principle of government responsibility in the field of health is firmly established in this country. One of the earliest acts of Congress, in 1798, established a compulsory health insurance system for merchant seamen. That was the beginning of what is now the Public Health Service. Long ago the Government took over the care of mental, tubercular and chronic disease for the simple reason that neither individuals nor private enterprise medicine could carry this burden. What private support could not do, public support was required to do. What the people could not do for themselves, the Government did.

In recent years the area of medicine that the people could not handle for themselves has greatly enlarged. We have gradually turned over to Government control and operation a larger and larger share of the medical care problem. We have turned increasingly to Government for subsidies in one form or another. We have progressively diminished the relative importance of the voluntary hospital and the private doctor; and we have done all this in the name of free, private enterprise, steadfastly proclaiming our distaste for socialism. In plain words, we have for years been observing a rapid growth in socialized medicine—all in the name of private enterprise. Adoption of national health insurance would almost certainly check this trend.

In fact, the Administration has proposed this solution to our problem of distributing medical care not only because it meets the problem of bringing adequate medical care to all of our people but also because this is the way—and perhaps the only way—to keep our hospitals free, to prevent the socialization of medicine, and to assure a sound economic structure for the healthy and continued growth of free private medicine.

Only one out of five families in America can today afford anything like adequate medical care. The American Medical Association itself is on record as stating that only 20 percent of our population can meet the cost of serious illness without outside help. What, then, about the 80 percent? Are we to let them go without medical care, or are we to provide for them on a charity basis?

National health insurance is a simple and logical answer to this dilemma which avoids either extreme. It recognizes that purchasing power for modern medical care cannot be marshaled effectively except under a Nation-wide system of prepaid medical care under which the economic risks of illness are spread over the whole population and the costs of medical care are related to the individual family's ability to pay.

The insurance principle, as applied to medicine, is not, of course, new. It has been repeatedly recommended by professional and lay groups since 1932 when a Commission headed by Dr. Ray Lyman Wilbur, a member of the Hoover cabinet and a former president of the AMA found it the answer to our problem. We have had long experience with commercial health insurance. And during the past 10 or 15 years we have seen a very rapid growth of the so-called voluntary health insurance plans.

But these are not social insurance plans. Their premiums are not based on ability to pay and are therefore out of reach of millions of the families that most need them. It is no accident, therefore, that the distribution of voluntary insurance policies follows the national income pattern in the same manner that the distribution of medical facilities does. Voluntary insurance fails to increase purchasing power in the medically undernourished areas and therefore fails to solve the basic problem with which we are confronted.

Some claim that more than 50,000,000 people are now covered by voluntary health insurance. The figures show, however, that only some three and a half million people, or less than 2½ percent of the population, have anything like comprehensive medical care. The remainder have varying degrees of very partial protection—in most instances covering only a minor portion of their medical costs. And nearly 100,000,000 people have no such protection at all.

The final proof of how inadequately voluntary insurance is meeting the medical needs of the American people is the fact that in 1947 all of the voluntary plans combined, including both good and bad, paid less than 10 percent of the total amount spent on medical care during that year throughout the country. For the remaining 90 percent of their doctors' and hospital bills the people had to sweat it out as they have always done.

Despite the inherent inadequacies of voluntary health insurance, in respect both to coverage and to protection offered, this method is being widely advanced today as an alternative to the President's program. Even the somewhat conservative-minded leaders of the American Medical Association have now come out in its favor though so tardily that their endorsement would appear to be a maneuver to avoid compulsory health insurance.

The AMA's support of voluntary health insurance possesses a certain degree of irony, since it was only a few short years ago that these same leaders were denouncing the Wilbur committee's proposals for voluntary insurance as "communism, inciting to revolution." A little later the AMA came to what seems to me to be a sounder conclusion about voluntary health insurance and I quote:

"Without some form of compulsion, voluntary health insurance fails of its objective * * * The young and healthy will not join, and the aged and sickly, if accepted, will raise the cost to a prohibitive point. * * * Sickness insurance cannot distribute the burden of sickness among the low-income classes unless it is compulsory."

In the light of this, it is difficult to believe that the doctors of this country are so solidly and unalterably opposed to national health insurance as the spokesmen for organized medicine today would have us believe.

Members of the committee are familiar, I am sure, with the broad outlines of this plan. I will only sketch the high lights. It proposes in effect a 3-percent pay-roll deduction on annual incomes up to $4,800, to be shared equally by employer and employee, on the same principle as old-age and survivors insurance is operated today. This would mean that a man earning $50 a week would pay 75 cents a week. If he earned less, he would pay less. If he earned more, he would pay more up to a maximum of $1.40 a week. Self-employed persons, such as lawyers, businessmen, and farmers, would pay 2¼ percent, or a maximum of $108 a year.

On the basis of the present social security law the program would cover about 85,000,000 people; but if social security coverage is extended as the President has recommended, health insurance would extend to some 124 to 130 million people. Those unable to work or who are dependent upon public assistance could have their insurance premiums paid for by various public or private agencies.

In return for these payments, a wage-earner would be assured that the bills for necessary medical care for himself, his family and his dependents would be paid.

Practical considerations would place some limit upon hospital benefits. The plan would exclude services in a mental or tuberculosis institution (which are now the responsibility of the individual States); and there would be a 30-day limit on mental and tuberculosis cases in a general hospital. There would also be a maximum limit of 60 days on hospital cases generally, except that this might later be raised when funds and facilities permit.

Dental, home nursing, and auxiliary services would be included to the extent that the personnel, facilities, and funds were available. Children would be given a priority on dental care.

The administration of the plan would be on a State and local basis. There would be a national board, appointed by the President and reporting to the Federal Security Administrator, which would be responsible for broad standards and principles of operation. But the actual community operation itself would be in the hands of the State and local people—doctors and representative citizens working together.

These State and local administrators would consult with the doctors participating in the plan to determine a fair scale of fees—so much for a home visit, so much for an office visit, so much for, say a tonsillectomy or delivering a baby, and so on.

Instead of free payments, the physician could elect to be paid on a strict capitation basis—so much per patient. It would be up to the individual doctor. There would be some limit set, after negotiation, on the number of patients for whom a doctor could assume responsibility under the plan.

A patient would be free to choose his own doctor just as he does now, and to change his doctor if he so desired. A doctor would similarly be free to reject any patient he didn't want. No doctor would be required to practice under the plan. He could continue in independent practice if he chose, or he could combine an independent practice and an insurance practice just as he does now with the voluntary insurance plans. He would in no sense—and I underscore the statement—be an employee of the Government.

A physician operating under the plan would have to deal with the malingerers and hypochondriacs, precisely as he would have to deal with them under voluntary insurance. A good doctor has to learn how to deal with this problem even under the present system. And the experience of most voluntary and cooperative plans up to date has shown that this danger is highly overrated. Besides, as you well know, plenty of hypochondriacs are really sick—mentally—and in need of some sort of psychiatric attention.

As to administrative costs, they would be much less than the opponents of the program suggest, since we would utilize the existing wage records that are already established under social security insurance. As an estimate, I should say that the administrative cost of operation of national health insurance would be approximately 5 to 7½ percent, as against the average of 12 or 25 percent required to administer the present nonprofit health plans—and 20 to 50 percent for commercial plans.

The total cost of the plan cannot, of course, be determined with accuracy until the system has been in operation for some time. Broadly speaking, however, it would involve no major increased burden on our national economy. The American people are now spending about $7,000,000,000 annually on personal payments for doctors, hospitals, and related medical expenses. Pay-roll deductions should be sufficient to meet the greater part of these costs. Whatever difference was involved, the Government would make up as underwriter, though definite limits to this obligation will undoubtedly be set by Congress.

It is sometimes said that national health insurance would result in the deterioration of medical standards. To that, the reply should be "for whom?" Undoubtedly, at the outset, the pressures on an admittedly short supply of doctors would be heavy. But, as more doctors were trained, more hospitals were built to meet the demand—the end result would be to raise the standard of medical care throughout the country. High standards of medical care which are, as now, at the almost exclusive command of the comparatively well-to-do, are no answer to the over-all health problem of the United States. Our aim is to make these same high standards available for our whole population.

Abraham Lincoln once said that it is the business of Government to do for the people what they, as individuals, cannot do for themselves, or cannot do as well. And I think the responsibility of providing a means whereby Americans can secure adequate medical care for themselves and their families at a cost they can afford, comes within this description.

Mr. Priest. The committee will stand adjourned until 10 o'clock Tuesday, May 24.

(Thereupon, at 11:10 a. m., the committee adjourned until 10 a. m. Tuesday, May 24, 1949.)

NATIONAL HEALTH PLAN

TUESDAY, MAY 24, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The subcommittee will come to order.

The subcommittee is meeting again this morning for a continuation of hearings on the bills, H. R. 4312 and H. R. 4313.

May the Chair state at this time that circumstances over which the committee has had no control have developed and it will be necessary again today perhaps to shorten the morning session and will not be possible, under the legislative situation on the floor, to hold an afternoon session.

We will proceed just as expeditiously as possible and the Chair, on behalf of the committee, wishes to assure everybody that even though there may be some irregularity in the schedule as announced, that it is the intention of the subcommittee to hear in these general hearings all witnesses who have been scheduled even if we have to put some of them over to the date of June 7, when we had expected to begin hearing the bill, title by title, and hearing all identical or similarly related bills at the same time.

We are proceeding today with hearings only on the over-all bill, with general statements.

As previously announced, it is our plan later to take up this bill, title by title.

Our first witness this morning will be Mr. Albert D. Lasker, a very prominent businessman from the State of New York, who has for many years been interested in health problems.

Mr. Lasker, will you come forward.

STATEMENT OF ALBERT D. LASKER, NEW YORK, N. Y.

Mr. Lasker. Mr. Chairman and gentlemen of the committee, I cannot qualify as an expert on the technical or clinical or scientific phases of medical practice. In that respect we laymen may be all in the same boat. Yet I think I do qualify as an expert on a number of other grounds. First, I am an expert sufferer, and thus qualified to plead the cause of others who, in their own persons or in the illness of family and close relations, have learned at first hand the agony of severe illness and the manner in which financial difficulties accentuate and sharpen that agony. In this sense, I am in no way unique. I am certain that all of you here can, in some way, match the experience I want to tell you, ever so briefly, about.

As a young man of very modest means, I married. A short time later my wife was taken with a grave illness—an illness that continued intermittently for 34 years, till her death. Within the first year of that illness, medical bills completely wiped out the small savings upon which we had so boldly ventured into matrimony. The blow was a staggering one to me. To my sick wife, it was an added burden, a constant worry and concern that no ill person should be asked to bear. I was fortunate in that my business ventures were successful. I was able to stay one jump ahead of the onrushing bills. As a young man in business in a period of economic expansion, I got by. But I know and you know that many millions of others, working on fixed salaries or struggling to make a go of small shops, farms, or limited small businesses, have suffered gravely when subjected to the same devastating strain. It was only good fortune that saved me from being overwhelmed by the cost of a major medical disaster. Yet I know even then that I was among the very few so situated.

In speaking as one who has had to meet sickness bills, I am sure I speak of an experience common to us all. Certainly most of you, no matter how well off you may be today, have at some time and in some degree faced this same problem. It is this very knowledge, that we all are and have been sufferers from the inadequacy of provisions for meeting the cost of medical care, that inspires my great confidence that we shall find a solution to this grave and pressing problem.

While, as a sufferer, I may be qualified to speak emotionally on the need for this solution, one would need further to qualify as an expert to justify taking the time of this committee to discuss methods and means. I believe that I do so qualify as a voter, citizen, and taxpayer, in which latter capacity I have been privileged, thanks to our democratic system and the vast opportunities which America offers its sons, to pay, for a long term of years, taxes running into large figures. Whatever bill you eventually arrive at, I shall be privileged—and I mean privileged—to pay some portion of the ultimate cost for administration and for direct aid, through my taxes.

I think I qualify, too, as an expert because I have spent all of my life in business; in fairly big business. The businesses I have owned or advised or been a part owner in have employed and still employ tens of thousands of people. Just as you must plan for the welfare of all the people, I have played a part in planning for the welfare of these employees—and that, in many instances, involved their health and the health of their families. Like most other businessmen, I have long been aware of the fact—you can't miss it if you are in business—that productivity, the key to the prosperity of employer and employee alike, falls whenever sickness strikes. American industry in recent years has lost about 600,000,000 man-days of productivity a year because of sickness. Certainly if we worry about reducing the economic losses of strikes, we must worry quite as much if not more, about such staggering losses from sickness.

Even when our employees are not themselves sick, illness of others may take a cut out of their productivity. Let any member of the family fall ill; let even the threat of illness, the worry about maybe falling ill, strike any of us and our productivity falls off.

As a businessman, I have specialized in distribution and merchandising. And, of course, that is exactly the problem you are facing up to when you write or rewrite these health bills. You've got to find a way of distributing medical care more widely. The product itself is in universal demand. But four-fifths of our citizens cannot afford a serious illness. They cannot afford enough medical care, nor can they afford to do without it. We cannot afford to let them do without it.

It is expertly estimated that today our national expenditure for medical care totals over $8,000,000,000 a year. Over $6,000,000,000, or more than three-quarters of this total, comes out of the pockets of the people directly. Nearly one-quarter of this, about $2,000,000,000, comes indirectly from the people through their local, State, and Federal Governments. I mention these figures because we should have in mind what we are spending for medical care now. Most of the $6,000,000,000 is paid by sick people at the time when they are sick. Since people cannot predict in advance when they will be sick, they cannot plan in advance to meet their sickness bills. Sickness bills fall upon families in unpredictable lumps. This is why we need health insurance, through which the costs of sickness are paid by the people while they are well and at work and therefore are prepaid when they get sick.

Only comparatively few people have incomes that can swing unpredictable sickness bills without trouble.

Way back in 1939 the American Medical Association published a chart which stated that families with incomes under $3,000 per year need help in varying degrees to meet the cost of serious illness. Nearly 1 family in 3, or almost 45,000,000, people now have incomes between $3,000 and $5,000 a year. People with such incomes cannot afford serious illness. Today $3,000 must be upped to about $5,000 to mean the same thing in purchasing power as in 1939, and at least 79 percent of our people have family incomes under $5,000. Almost half of our people, about 70,000,000, today have family incomes below $3,000.

At the lowest level are the bottom 5 or 10 percent of the people who have no incomes, or incomes too small to pay their rent or their grocery bills. There are some proposals to the effect that if we provided medical care for the bottom 5 or 10 percent we would do all that needs to be done. I don't agree with those proposals. Suppose we limited a national medical plan to the bottom 5 or 10 percent of our people.

What then? You'll take care, largely, of the chronically indigent—those who, by and large, can never contribute much to our general productivity. You will not begin to do anything for the vast lower middle class—the people who pay taxes, grow our food, make our cars, operate our factories, run our offices. In fact, that vast group which is the very backbone of our American democracy. They will still, most times, have to defer going to the doctor for fear of the bad news they will get when he examines them. They will still have to go to loan sharks, sell their few bonds, hock their car, and worry themselves doubly sick as a punishment, one might think for being a shade above the subsistence and relief and indigence levels.

Now the bills before you—H. R. 4312 and 4313—call for prepaid medical care—for buying medical care on the installment plan—with an insurance pool to which the beneficiaries would contribute and from which all would draw when the need arose. I hear that called socialized medicine—but then, in my day I have heard a lot of other things we all now accept, called socialistic. When I was a boy, the first law was passed creating the Interstate Commerce Commission, and most solid citizens felt, honestly that the ICC spelled the end of private enterprise. We had the same sort of opposition to the Federal Reserve bill and the SEC and the Federal Trade Commission and Federal bank-deposit insurance—all were opposed by some as the end of private enterprise. Even the Pure Food and Drug Act was so opposed, and it is to the everlasting credit of the American Medical Association that the association was not stopped by the cries of "socialism," but fought and fought until it convinced Congress and the country that we needed such a bill, with teeth in it. I was on the opposite side of the fence on that pure food bill. I had many food and drug connections, and I shared their fears that this would unfairly injure the food and drug industries. I've since learned to be grateful for that act—and in the process, I've learned that socialism is often a word used to scare us when argument cannot convince us.

Frankly, gentlemen, I do not think insurance, for any purpose, is socialism. It's as American as corn or apple pie. That is why Congress has passed a dozen or more Federal insurance programs—crops insurance, war-risk insurance, unemployment insurance, old-age insurance, and so on down the line. If you adopt the insurance principle to provide medical care for all, you will merely be following an accepted American practice—doing in medicine what most of you have long since voted to do in other fields.

But more than that, you will be putting a premium on self-help. Instead of providing medical care as a dole for the indigent, you will be making it the bought-and-paid-for right of free men and women—you will administer an insurance pool—but the people will pay their own way. No swarms of investigators will have to check up on whether our fellow Americans are really indigent enough to deserve a Government hand-out—no citizen covered by this bill will have to undergo the shame of public pauperization to secure medical care for a sick child. The insurance principle is certainly the democratic way of solving this problem, because it will use the state to serve the people rather than to master and regiment and police them.

But will it work? As you and I understand, this bill does not cover the entire population, nor does it cover all medical costs. But it does cover all the essential medical costs, namely, the complete service of physicians and hospitalization with its important incidentals of laboratory and other scientific work. True, the people covered will pay taxes to the Federal Government to meet the cost of their health insurance. But most of that money will come right from where it now comes, from pockets of people who meet the medical bills today.

It has been said that there will be some time lag, after we begin collecting the tax for medical-care insurance, before adequate medical care will become available to all people at all places. Obviously, removing the financial barriers which now dam up the public demand for medical care will not cause a shortage but will bring to light the shortage of physicians and medical-care facilities which now exists in some areas. But surely it has never been the American way to refuse to march forward to a better and more expansive life because we have to face obstacles on the way. Running away from a problem is no solution.

But before not too long, I think we will find our cost of sickness insurance falling. Because people will be going to their doctors early. Consider cancer. It has been reliably calculated that 17,000,000 Americans now living will die of this disease if we do not find new or better ways of curing it. Before they die, they will suffer many months—often many years—of ceaseless torture and incredible expense. But many types of cancer, caught early, are even now curable. If we can make it possible for people to detect and treat cancer in its early stages, we cannot only save the lives of nearly half who now die—important as that will be—but we can also save the expense of their chronic, long-drawn-out illness. The same is true of heart disease in many cases and of a score of other illnesses. Prepaid insurance will be an incentive for preventive medicine, and that in time should bring costs down while vastly increasing the well-being and the productivity of millions of people.

We already have one tremendous group of our citizens, the veterans, covered by a system of socialized medical care, paid for entirely out of general Federal Treasury funds. But do we want to extend that system of subsidy from the General Treasury funds to millions more—without responsibility and without direct contributions from the beneficiaries? I for one do not. If times of stress, such as we experienced in 1932, ever come again, the beneficiaries under any bill based on the charity principle would multiply beyond any present concept, and constitute a burden on the Treasury when the Treasury could least afford it.

The national health insurance bill now before you includes, as you know, much more than health insurance. Because we have a shortage of doctors and other professionals and of hospital beds, the bill provides Federal aid to medical schools to enable them to enlarge and improve their facilities, and scholarships to States to help more capable young men and women from all parts of the country to obtain training.

The bill, as you know, also provides aid to medical research, additional Federal funds to build hospitals, health centers, and clinics in places that need them. Also the bill provides special help to bring doctors and public health departments into places that lack them. Thus this bill as a whole offers a rounded national program. On the one side it insures stable purchasing power for medical care among the majority of our people. On the other side the bill provides for making good as rapidly as possible the shortages that we have of the professional people who furnish us health services and of the hospitals and other material facilities with which our professionals must do their work.

There is nothing in the whole medical field that gives me more immediate concern than Federal aid to medical schools. It takes at least 5 years after you start a doctor at his professional training before you have a doctor. For that reason national aid to our medical schools and scholarships for students is a program that ought to be undertaken without any delay. This aid to medical education should have been enacted by Congress yesterday. It should not wait until tomorrow. It should have priority today.

Of continuing major concern should be the field of medical research. Through a forward-looking program for research, engaging the services of our scientists and institutions of learning, we can hope some day to solve some of the causes of major illness. The profit we can conjure from this is beyond estimate in the possibilities of saving life, saving people from dread illness, saving them for usefulness in society and ultimately reducing greatly the national medical bill. Medical education and research are the bases on which we must build our entire medical structure.

In this bill the promotion of education and research is provided for, combined with economic measures which would support the doctors adequately and which would enable the knowledge gained from research to be put to practical use fully and promptly.

I plead for this whole national health program on the basis of good business, good democracy, and true humanity. I plead with you to help America go forward medically, just as we have in our long history gone forward, to make new world records in political freedom, human welfare, and industrial accomplishments.

Mr. Priest. Thank you very much, Mr. Lasker. We appreciate your statement and I think whether a person agrees with you all of the way or whether he does not, he can certainly appreciate the background that leads you to make this statement and the zeal and earnestness with which you have made your statement before the committee.

I appreciate particularly the emphasis you place on aid for medical education. I think you are certainly correct in emphasizing that by saying that it should have been passed yesterday.

I may have one or two other questions later, but there may be some committee members with questions at this time.

Mr. Biemiller. Mr. Chairman.

Mr. Priest. Mr. Biemiller.

Mr. Biemiller. Mr. Chairman, I would like to raise about two points.

Mr. Lasker, am I correct in understanding that in your career you were at one time a Government official?

Mr. Lasker. Yes.

Mr. Biemiller. What was the position that you held?

Mr. Lasker. I was, in the Harding administration, Chairman of the United States Shipping Board, which is now the Maritime Commission. And may I say, parenthetically, that at the President's insistence, it became my duty to represent the Administration before the Congress for a ship subsidy bill, the first having been offered, I think, in 1912 by Senators Hanna and Fry, and defeated in the Congress. It was as much anathema to many people, as health insurance is today; but subsequently, as the result of the two prior defeats, in the Roosevelt administration, the country and the Congress accepted the principle of ship subsidy and still does.

Mr. Biemiller. The point I wanted to get at is that, as you know, there are some critical of health insurance who insist that the old bugaboo of government bureaucracy would kill the program and make it inefficient, I wondered if, as one who has had considerable experience as a businessman and some experience as Government administrator, you would care to comment on that point.

Mr. Lasker. Yes. Not to be facetious, I would like to tell you just briefly a little story. I once went with another man to see a man for a charity contribution, and that man would not give us anything, so we asked him, would he give us his reason for not contributing; at least, he should give that much, and he said: "Yes, I will give you my reasons."

We said, "What are they"?

He said, "I do not like mince pie."

We said, "You do not like mince pie. What has that to do with it"?

He said, "When you do not want to do anything one excuse is as good as another."

Now, to my notion, this cry of socialism and cry of bureaucracy is all "mince pie."

Anyone who will read this bill carefully will see that it changes nothing really in the practice of medicine as it is practiced today, except in the economic end, that is, in the ability of people to pay. It is broken down into local communities, down to the grass roots, and the people in each community decide, in a democratic way, just how they want the funds administered—that is, the doctors and the local communities arrive at what the fees shall be; the doctors are free to select or reject their own patients; the patient is free to select or quit the doctor; the hospitals are not to be owned by the Government. There can be no big bureaucratic control, because the only control from Washington under this bill is in the setting up of standards, and certainly I do not think in very many places, the very high standards set up today by the medical associations are lived up to, because we have not the facilities to live up to them.

Mr. Biemiller. I am pleased to have that statement about the bill from one who has such an eminent position in the field of business and one who has served as a Government administrator under a Republican administration. Some have said that this is a partisan measure and I do not think it is at all. I think it is a measure in the interest of the welfare of all of the people, and should be supported by good Republicans as well as good Democrats.

Mr. Lasker. I, for 2 years, was assistant chairman under Mr. Will H. Hays, chairman of the Republican National Committee, and for 20 years, I was one of the men who raised the big money for the Republicans in Illinois.

I do not think the right to feel that the American people should have proper medicine belongs to any party or any partisan. I have just as much right as a businessman and a capitalist to be for this as people who have nothing.

Mr. Biemiller. I concur heartily in your statement.

That is all, Mr. Chairman.

Mr. O'Hara. Mr. Chairman.

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. Mr. Lasker, of course, I have known about you and your very sincere charitable work over a period of many years.

Let me say that the fact that you were at one time associated with the Republican Party, prompts me to say that I hope you will still continue that affiliation.

Mr. Lasker. I will vote for the Republican Party this time, if they will come out for national-health insurance. You can have my vote.

Mr. O'Hara. Well, I hope that we can get it for other reasons, too.

Mr. Lasker. I am cheaply bought.

Mr. O'Hara. Mr. Lasker, some emphasis has been placed by you, and the chairman, upon the scholastic or the matter of scholarships in medicine.

Have you had any experience with your young friends trying to get in a medical school in recent years? I mean, the difficulty they have had in trying to get into medical schools because of the limited number that may enter?

Mr. Lasker. Yes; I made the statement I did because I have gotten in contact and had lengthy exchange of views with the heads of the greatest medical school in the United States and I know directly from them that they are on the verge of a financial catastrophe.

I do not believe—and I may be mistaken—I may be speaking in too lurid terms—that there is a medical school in America which, unless large private funds and Government funds, both, are made available, and I am for the raising of both—can in 5 years fail to have a crisis. That goes not only for the small medical schools, but I say includes medical schools attached to our most famous universities.

Mr. O'Hara. Well, my point, Mr. Lasker, is that the provisions for scholarships are not going to take care of one of the things that has bothered me much.

It is my opinion at least—and I happen to have a bowing acquaintance with one of the largest medical schools in the country—and my contact in recent years has been in an endeavor to try to get some young student who wanted to be a doctor and who has apparently the scholastic ability to be one, to gain entrance to a medical school.

Now, I think it is a serious situation. The schools, as I understand it, say that they can only take in 100 or 150 or 175, and that is all.

Mr. Lasker. That is right.

Mr. O'Hara. Now, I do not know what is wrong.

So, I think we have to look a little deeper than just a matter of scholarships, Mr. Lasker.

Mr. Lasker. Are you speaking of race discrimination?

Mr. O'Hara. No; I was just speaking of the matter of the limitation as to how many schools will take in.

Mr. Lasker. The limit that they will take in is limited by their physical facilities; limited by their hospital facilites; limited by their staff of teachers, and, of course, all those limitations revolve around one thing—money.

Mr. Biemiller. Will the gentleman yield, Mr. Chairman.

Mr. O'Hara. I will yield.

Mr. Biemiller. I just want to point out that the bill does provide for grants to medical schools over and above scholarships, so that they may enlarge their facilities and enlarge their teaching staffs.

Mr. O'Hara. I have in mind some State universities which have tremendous grants of money, that still operate on the basis of a very low number that can enter in the medical school.

Now, you and I would agree that in the interest of having the best men and women become doctors that we have no quarrel with that; but do you have any feeling that there is an undue limitation in our medical schools as to the number which can enter?

Mr. Lasker. No; the only thing that I have run into is a thing we all know, that has been charged, that there are such things as race discriminations. It is very difficult for a Negro to get into many medical societies, after he completes his education, much less get an opportunity for any education.

Mr. O'Hara. I was not referring to that.

Mr. Lasker. No, but I have not run into anything excepting the shortage of money. I would not know as to any State schools. I have to say, Mr. O'Hara, my contact has been with the larger and more important medical schools, the schools that lead in the teaching of medicine, and turning out of doctors, and they all have a financial problem.

In fact, we are undertaking to organize to raise money privately throughout the Nation to spread horizontally through medical schools, if that is possible; that is, a group.

Mr. O'Hara. Mr. Lasker, have you given any personal study to the situation of our English neighbors and the operation of their so-called socialized medicine field?

Mr. Lasker. Yes. I would like to go back to your prior question.

Mr. O'Hara. Very well.

Mr. Lasker. Of course, you know this bill has a whole section, as Mr. Biemiller pointed out, on medical education, and provides for assistance to all schools in a range of, I think $300 to $1,700 per student and it also provides scholarships. So that it is only, in medicine, through Government aid, that I see medical education can be helped, and before I answer your question, I just want to speak one sentence, that whatever your economic basis of distribution of medicine in the United States is, whether we continue on the present system, which haphazardly grew up through the years, or whether we have a successful voluntary system, which I would like to see, but feel is impossible to achieve, or whether we have a system of national health insurance, medical education is the basis on which it must be built, and medicine in America, 10 years from today, will collapse unless the Federal Government comes to the aid of the medical schools.

Mr. O'Hara. Mr. Lasker, I still want to go back to the question of whether or not it is not a fact that every medical school in the country now has more students who are capable of going to school, whom they cannot take in, than they are able to take in?

Mr. Lasker. Yes. There would be no shortage. I did not understand your question. There will be no shortage of students if we make it economically possible for them to study.

Mr. O'Hara. Well, then, we have got to start out on a program of giving every medical school a grant of some kind to build up their hospital facilities, and all of the facilities that are necessary for medical schools; is that right?

Mr. Lasker. In my belief it is sure to come. There are proposals in this bill that are controversial, but aid to medical education and medical research are two things the Congress will have to provide for and the longer delayed, the more tragedy for the American people.

Now, as to your question regarding Britain.

I am not an expert on the British medical system. If reading newspapers and magazines and pamphlets and talking to people about it—mostly people like-minded with me—makes me an expert, then I am an expert; but this much I know—the British plan has very little relationship to the plan proposed by the bill before you. In the British plan, 85 percent of the bill for medical care is paid out of the Royal Treasury. In fact, in our Veterans' Bureau we pay 100 percent. The British Treasury pays 85 percent for everyone's bills.

Our bill provides that the people pay for it themselves, that is, the people and their empolyers. Ours is pure and simple health insurance. Theirs is socialized medicine, largely. I call it socialized medicine when the Government owns all the facilities and practically pays all the bills out of General Treasury funds.

The Government in Britain owns all of the hospitals and, of course, if you own all of the hospitals and operate them, that does make the Government a party to medical care and that does bring in the swarm of bureaucrats.

Nothing like that is proposed for this country. It is entirely different. This is a purely American plan.

Mr. O'Hara. How much would it cost, do you think, to provide what you and my colleague, Mr. Biemiller, might think would be necessary for grants to medical schools in the country?

Mr. Lasker. I want to finish just a sentence more about the British, in reply to your question, but I am sure, and of this there can be no doubt, the most popular thing the Labor Party has done in England has been to adopt their system of socialized medicine which, of course, was not originally a Labor Party program. It was made on a report from a Royal commission under a man whom I think would be a Republican, had he been in this country, Winston Churchill, and, if the Conservatives got in, the last thing they would change would be the system of so-called health insurance in England.

When I was last in Washington, which was February 18, I saw in the Washington Post, and put in my pocket, this short item. It is dated London, February 17.

> The Conservative Party disclosed tonight that it would not scrap Britain's national health organization, should it be returned to power. The disclosure came as the House of Commons voted more money to meet unexpectedly high cost of socialized medicine. Conservative spokesman Harvey Asherton, in commenting on the added cost said any suggestions that his party would scrap the law were absolutely false—

And so on.

Mr. O'Hara. Well, I have reason to believe that the British will probably take care of their own problems. They usually do.

Mr. Lasker. We are taking care of some of them.

Mr. O'Hara. We seem to finance them as much as we can.

Mr. Lasker. Now, Mr. O'Hara, you ask if I have any idea what Federal aid to medical education would cost. I would, roughly speaking, think that the medical schools of America would need (this is without added facilities for their present needs, and without raising standards) some $25,000,000 to $35,000,000 a year. Remember that would not allow for anything in the way of added facilities or raising of standards.

Mr. O'Hara. Well, some of them have magnificant facilities already. There is no question about that, Mr. Lasker.

Mr. Lasker. Some of them do.

Mr. O'Hara. But the point I am still driving at is that there is still the lack of numbers admitted to the medical schools.

Now, I think that is brought about by many, many reasons. I cannot speak for all the schools, but I know definitely that there is a limitation as to the number that can enter each year, and consequently the number who graduate as doctors each year is limited.

Mr. LASKER. The main reason is money, because if they had the money they could expand their schools and the smaller schools could be expanded.

If the larger universities will not turn out the number of doctors we need, then we must see that new schools turn them out. It is a difficult process.

Mr. O'HARA. Would you recommend a Government school for that purpose?

Mr. LASKER. No, sir; nor would I recommend when the grant is given that the Government have one thing to say about it thereafter and the law before you proposes that after the grant is made, the Government has nothing to say.

Mr. O'HARA. Mr. Lasker, under the committee rules, I have exercised my privilege of 5 minutes, so I must yield.

Mr. LASKER. Yes.

Mr. SADOWSKI. Mr. Wilson.

Mr. WILSON. Mr. Chairman, the query that I have is with relation to title III of the bill.

I notice in your statement, your printed statement on page 5, you speak of the bill providing aid to medical research and additional Federal funds to build hospitals, health centers, and clinics in places that need them, and I notice in the early part of your statement in reference to your own early life, that you received a stunning blow in the early illness of your own wife and the medical bills and burdens because of them.

I am thinking along this line at the moment: Did those medical bills include hospital bills?

Mr. LASKER. No. My wife had an illness which came to her overnight. I lived in Chicago and we were en route to New York and were spending the week end with her parents in Buffalo when she took ill in her parents' home and in those days, which was 1902, very few people were taken to hospitals. There were very little hospital facilities.

Mr. WILSON. With your knowledge of today and the happenings of the day, the medical bills incurred would normally include hospitals, that is correct, is it not?

Mr. LASKER. Yes, today it is utterly different.

Mr. WILSON. Many have said to me, and my own personal experience indicates that a large percentage of the medical bill includes a large amount for hospital care. Have you found it so?

Mr. LASKER. Yes, sir; hospital care. In the early part of the century, we did not have—remember this was in the early days of X-rays—there was not very much service that could be performed at the hospital. Today, with all of the mechanical and scientitfic discoveries and inventions, the hospital has become a very important center in illness and can treat in a way that cannot be remotely accomplished at home.

Mr. WILSON. Have you found in your experiences with the projects that you have been interested in throughout your life, that doctors themselves shun away from the operation and administration of the private hospitals?

Mr. LASKER. I cannot answer that they shun away; I can answer that there are a few very eminent hospitals that are run by doctors, such as Lehey Clinic, Boston, the Mayo Clinic in Rochester, Minn., and several other eminent hospitals, but usually the hospitals have been community supported, because they have lost money, and in order to be community supported they have to raise money, and in the raising of money, naturally, laymen came into control of the hospitals, and I believe control of the hospitals should be in lay hands.

Mr. WILSON. My purpose in interrogating you the way that I have propounded these questions is to lead to this question. From your knowledge of the subject of subsidy to the shipping interests, what do you think about making proper provision for not only hospital construction but for the bringing into the community that needs them, hospitals and hospital facilities?

Mr. LASKER. The reason I am so strong for health being considered on a national basis is because we have not those facilities in many communities. The richer the community the more facilities we have. The poorer the community the less facilities we have, and I certainly am for the extension of these facilities.

Mr. WILSON. Would you go so far as to recommend subsidies by the Government not only for the construction but for the administration of the hospitals?

Mr. LASKER. If we have national health insurance, I do not believe administration will require subsidies from the Government. That is why I am for national health insurance. If all of the well pay every week, then I believe, in a very short time, the sick beds will be taken care of. That is my deep conviction.

Mr. WILSON. I did not follow your last answer. Do you mean the problem will be taken care of by providing for more beds?

Mr. LASKER. There will be such a big pool of money that there will be no need for free care. Every bed will be paid for by each patient's insurance.

Mr. WILSON. That is all, Mr. Chairman.

Mr. PRIEST. Mr. Gillette.

Mr. GILLETTE. No questions.

Mr. PRIEST. Mr. Sadowski.

Mr. SADOWSKI. No questions.

Mr. PRIEST. Mr. Bennett.

Mr. BENNETT. I have no questions.

Mr. PRIEST. Mr. Scott.

Mr. SCOTT. Mr. Lasker, on Sunday a Senator made the statement that this bill, providing for compulsory, prepaid medical insurance, would not cost the taxpayers a cent. The statement was made on the radio. Do you agree with that?

Mr. LASKER. First, I did not hear the Senator; secondly, if I differ with him, I hope he will not take affront.

No, I do not agree that it will not cost the taxpayers anything; but who is the taxpayer? The taxpayer is all of us. It is the same people who pay the medical bills now.

If your question is that for a period there will be, have to be funds out of the Treasury, appropriated out of the Treasury——

Mr. SCOTT. That is really what I am getting at.

Mr. LASKER. Yes. There is no use discussing the bill unless we look at what we are discussing; but I believe that the sum required from the Treasury will be comparatively small, as compared to the whole bill, and I believe that in the course of time—now, I cannot say how many years—that gradually the Treasury will be called on for less and less.

Of course, the Treasury will be contributing money toward the building of hospitals. It does now.

You do not want to forget that the Treasury is now contributing $2,000,000 to our medical bills. I believe a lot of that could be oriented if we have national health insurance.

So I would not want to predict how much money, in comparison to the whole bill, to the whole cost, it will be, but in fact, yes. You know the Government never gets anything unless it costs it money.

Mr. SCOTT. And more than it cost the individual, as a rule?

Mr. LASKER. Excepting that this breaks—this proposal is rather novel in that it breaks the whole administration of the plan down to a local level.

Mr. SCOTT. I am speaking, Mr. Lasker, of the Hoover Commission report in which they comment on the waste in the building of too many hospitals in various locations and other wasteful practices.

What assurance do we have that in the administration of this bill that the Government would be more thrifty than it is under the Veterans' Administration?

Mr. LASKER. I am glad you asked me that question, because I can answer your question directly by referring to the bill itself.

I may say that I do not know how many proponents of the bill would agree with me in what I am about to say, but then I am used to being wrong.

The bill provides that there be appointed a board or a council consisting of doctor, scientists, and public-spirited citizens with whom the Surgeon General must confer and must consult on the various standards, policies, and rules of administration.

Now, I believe that instead of mere consultation the Surgeon General should have to get concurrence by such a board and there should be broad concurrence all down the line to the smallest community, which local boards are provided for in the bill. If that were done, then you would have a system that would protect the Treasury, the insured, the hospital, and the doctor in the fullest measure.

Mr. SCOTT. I am just wondering whether we would also thereby be protected—and I may say I have worked for the Government—whether we would be protected from the attitude which exists toward the end of the fiscal year: "Let us be sure and use up the money, because another appropriation bill is coming up."

Mr. LASKER. I think we would, because you must remember that just as we have parent-teachers associations, I believe if we had national health insurance, there would spring up all over the country groups like the parent-teachers associations and I think public opinion would watch this and I think if a bill like this were passed it would be considered a great honor by eminent and capable people to be on such a board. I believe we could prove that we could make such a system of insurance work within our democratic principles, but I believe the key to it—and there I differ with this bill—is that it be mandatory that the boards or councils concur with the administrators in all actions.

Mr. Scott. That, I appreciate, is a very interesting comment.

I have been thinking how often public opinion has failed to keep us militarily prepared, and I am just wondering whether public opinion would be successful in keeping us medically prepared.

Mr. Lasker. Militarily, the son or the father is taken into the Army, and the civilians do not come every moment in contact with military affairs. But those who are ill—and that covers a big segment of the population every day and throughout the year, and still larger groups of well people are affected by the illnesses of their associates and relatives, all these would have an interest that would be great, as is evidenced, I think, by the parent-teachers associations throughout the country on public schools because parents are in daily touch with the problems.

Mr. Scott. Well, we have certainly got to do something about the public health. There is no question about that. The question is just what.

Thank you very much.

Mr. Lasker. Thank you, sir.

Mr. Priest. Are there any further questions?

Mr. O'Hara. Yes; I would like to ask Mr. Lasker one question.

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. Mr. Lasker, how many people, employed by the Government, would be necessary to operate this bill, in your opinion?

I am speaking now of the bill which has 163 pages, H. R. 4312.

Mr. Lasker. I can answer that, based on what I have been told by people who have studied it, and not on a study which I have made. From my own knowledge, I am not competent to make such a statement, but based on statements of people in whom I have confidence, there would be comparatively few Federal employees—at most, maybe 2,000—because, as I say, the money would be collected just as the social security is collected now. It would be on the same blank. That would not take any extra help. The direct administration would be entirely in the field on the local level. They would not be Federal employees. They would be local employees of the local boards. They would be State employees, and the total of that would run to some 50,000.

You must, however, not forget that today we have large numbers of people employed, privately, on similar work who would not then be employed. In other words, it would just be a transference, but they would not be Federal employees. The number of Federal employees would be very small, to carry out this bill.

Mr. Scott. Would you have any estimates of the cost of administration of the bill?

Mr. Lasker. No; I have not, but you must remember that for those who are insured today, there is a cost of administration, whether it is the Blue Cross or the Blue Shield, or by unions, or by private life-insurance companies, who, in addition, add a profit.

Mr. Scott. Will the gentleman yield for a comment? I have the impression Mr. O'Hara may be concerned about the discussion of the Blue Cross and the Blue Shield in connection with the blue-sky program.

Mr. Lasker. May I answer?

Mr. Scott. Yes.

Mr. LASKER. If you study the bill you will see there is no reason if the community says, "We wish to use our money entirely through Blue Cross and Blue Shield," they can make a contract with Blue Cross and Blue Shield. I have stated and I aver that this bill changes nothing in our present system.

Mr. O'HARA. Let me ask you a question there.

Mr. LASKER. The whole State can take Blue Cross or Blue Shield service when Blue Cross or Blue Shield operate comprehensive plans.

Mr. O'HARA. The thing that troubles me, Mr. Lasker, is that many people carry their own health insurance. You have indicated certain unions which provide for health protection of their members and private industry has its own form of health protection and retirement plans. Would you say that it is proper for those who provide their own to also be compelled by taxation to provide for those who do not?

Mr. LASKER. The bill provides for that. The local community can vote to spend the money in the same type of manner that it is being spent now. They can vote to spend it through union plans or any other plans.

In saying what I am about to say I want to protect myself from being misunderstood as being antilabor. The mine workers' union, for instance, started collecting a welfare fund of $50,000,000, I believe. Then it got to be $100,000,000 and then $200,000,000 a year.

Now, I do not mean that I am not for such funds, but I am calling attention to the fact that that money is ultimately paid by the taxpayer—so much a ton has been added to every ton of coal mined to provide the $200,000,000 a year.

Mr. O'HARA. Not to the taxpayer, to the consumer.

Mr. LASKER. The consumer and the taxpayer is the same man.

Mr. O'HARA. I am sorry, I have to disagree with you on that.

Mr. LASKER. I see where you just passed a sales tax in Washington.

Mr. O'HARA. That is right.

Mr. LASKER. That is the consumer.

Mr. O'HARA. You are talking about a different tax, however.

Mr. LASKER. That is right; it does not work out exactly, but in the over-all it works out that someone who has no say, pays the bill for the miners' welfare fund, and that means all of us for everyone uses coal, unless they sleep in the open.

Mr. O'HARA. Those who use coal.

Mr. LASKER. Everyone. If you are in a building you pay rent and the rent includes the cost of the coal. If you live in your own home you pay for coal. Every human being in America is paying a tax privately administered by a private sovereign body for medicine, for socialized medicine, which I am not for, for a particular group and I am saying if this is good for the miners it is good for all the people.

Mr. O'HARA. Mr. Lasker, I insist that I use oil.

Mr. LASKER. Correct, but I see that the Government is spending money to make oil synthetically out of coal so that we will catch up with ourselves some day.

Mr. BIEMILLER. I would like to make three brief comments, if I may. First, the blue sky has already been preempted in the field of health insurance. Most of the commercial health-insurance policies for individuals carry so many jokers that they ought to be banned under the antigambling ordinances because your chances of getting your money back are so slight.

Furthermore, the records show that on individual health-insurance policies less than 40 percent of the premiums paid are paid out in benefits, which is a pretty sorry record. I am not talking about the group policies that are sold because there is about an 80 percent return there.

Mr. Scott. May I ask if that is not also true of the social-security law? Considerably less than 40 percent of the amound paid in social-security contributions is paid out in the form of benefits. In fact, the fund is not kept by the Federal Government.

Mr. Biemiller. I am glad you brought that up. I am especially glad to have the chairman of the Republican Party bring that up. First of all, that is a different kind of fund than a health-insurance fund. That is a trust fund like any life-insurance trust fund. Secondly, as you well know, the funds of old-age and survivors insurance are invested in Government bonds, and I have yet to find any life-insurance company that does not have a considerable amount of its trust funds invested in Government bonds unless I read the records in the financial pages incorrectly.

In my opinion, the best investment today is in Government bonds. But, to get back to health insurance, several employers have talked to me recently and pointed out to me that with demands being made constantly by the unions for private health insurance funds of one sort or another that they are subjected to new strains and stresses in collective bargaining. I think there is rapidly developing an understanding among employers that it would be better if they had one plan with national coverage rather than to have the situation to which you refer.

Mr. Lasker. Mr. Biemiller, I really believe that if this bill does not pass at this time in 10 years from now the main proponents will be the National Manufacturers' Association for the reasons you give.

Mr. Biemiller. That would not surprise me.

The third comment I want to make is to clear up a possible misunderstanding of Mr. Lasker's testimony that while it is true that roughly there will be 50,000 employees needed, they will be local people and they will be, however, paid from the health insurance funds; they will not be put on State and local tax loads.

Mr. Lasker. No, they will be paid out of the insurance funds that are returned to the local community.

Mr. Biemiller. That is right.

Mr. Lasker. In concluding my answer to Mr. Scott, I want to say that today, under voluntary insurance there are only about 3,500,000 people comprehensively insured, and I might say that comprenhensively means to cover the whole cost of sickness. I was one of the founders of the Blue Cross in Chicago and therefore I have been in it from the beginning.

My wife was one of the founders of one of the largest comprehensive plans in America, the Health Insurance Plan of the City of Greater New York. So, I have had experience with voluntary plans and have been ardent for voluntary plans. It is, however, my experience with voluntary plans that has led me to believe that the problem of paying for sickness can only be solved on a national basis by national compulsory health insurance.

There are in this country today some 53,000,000 people who have some type of health insurance, either with Blue Cross or Blue Shield or with private companies or with industrial insurance. There are 3,500,000 people comprehensively insured. The Blue Cross has 33,000,000 members, of which 10,000,000 members are covered by the Blue Shield, which gives medical care. But, there is a limit to the amount of care one gets under those policies.

I see that General Hawley, for whom I have an outstanding and ardent respect, challenged a statement which I desire to repeat even in the face of his challenge. The Blue Cross and Blue Shield do not insure a family's illness bill on the average to quite as much as 33⅓ percent of the total bill in a year. In other words, the insured person is like a man who drops out of a 40-story window: he is insured to the sixteenth floor, but after that he is on his own. It is the need for comprehensive coverage of all the people that has brought me to being a proponent of this measure.

Mr. SCOTT. Mr. Lasker, then what you are speaking to is the necessity for the complete coverage of all citizens by compulsory prepaid medical care; is that not right?

Mr. LASKER. To begin with, I do not think that we have the facilities to take care of all the people. While I say I want to use my imagination, I want to be practical in my dreaming.

Mr. SCOTT. Therefore, the bill is discriminatory?

Mr. LASKER. We can undertake to grow from there.

Mr. SCOTT. In other words, the self-employed person, the drugstore proprietor, the grocery storekeeper, and the small-business man, as usual, he is caught in the cold because he is not where you can attach compulsory to him?

Mr. LASKER. If he is self-employed he must join if he is in industry, but he must pay the full premium himself. Naturally, he pays the half as the employer and the half as employee, so he pays the full premium but he is provided for, Mr. Scott.

Mr. SCOTT. Supposing he is a man making a start in a corner cigar-store or corner candy store, must he pay for himself?

Mr. LASKER. I am sorry you asked me that question.

Mr. BIEMILLER. He may elect to pay. Under the provisions there is a 3-percent premium presumably split between employer and employee. The premium for the self-employed as contemplated would be 2¼ percent. He may elect to join.

Mr. LASKER. I did not remember that detail.

Mr. PRIEST. The subcommittee is happy to have a member of the full committee who is not a member of the subcommittee, Mr. Hale. Do you have any questions, Mr. Hale?

Mr. HALE. I appreciate the opportunity of coming here to listen to the testimony on this subject.

Mr. PRIEST. Mr. Beckworth who is also a member of the full committee was present but he has left.

Mr. Lasker, we appreciate your coming here. I join with my colleague, Mr. O'Hara, in expressing appreciation for your great interest over a long period of time in matters relating to the improvement of the health of the people.

You have been before this committee before, Mrs. Lasker has been here, and shown a great interest and we are always happy to have you.

Mr. LASKER. May I thank the committee for its courtesy and attention, which I deeply appreciate.

Mr. PRIEST. Thank you, sir.

Mr. BIEMILLER. Mr. Chairman, may I make a request for a unanimous consent on behalf of Representative Dingell who testified here on the opening day?

Mr. PRIEST. Yes.

Mr. BIEMILLER. He said he wanted to include in the record the document of the Dallas (Tex.) Medical Journal on plan of action and thought he had done so but wanted to be sure.

Mr. PRIEST. Without objection, the request is granted.

(The information referred to was incorporated following the testimony of Mr. Dingell.)

Mr. PRIEST. We will proceed with the hearings until there is a quorum call. Is Dr. Channing Frothingham present? Will you be seated and give your full identification for the record?

STATEMENT OF DR. CHANNING FROTHINGHAM, CHAIRMAN, COMMITTEE FOR THE NATION'S HEALTH, BOSTON, MASS.

Dr. FROTHINGHAM. I am Channing Frothingham and I come from Boston, Mass., 101 Bay State Road; patients are always welcome.

Mr. PRIEST. You may proceed, Doctor.

Dr. FROTHINGHAM. I am proud to appear before this committee of the House of Representatives to register the support of the Committee for the Nation's Health in regard to House bills 4312 and 4313. It is important that you should realize that the Committee for the Nation's Health includes in its membership a cross section of the whole population, so you are hearing the opinion not of just one group of the population which might have a very biased point of view because of its narrow interests but the combined opinion of representatives of labor, the professions, the farmers, business in general, and so forth. In addition to appearing before you as the representative of the Committee for the Nation's Health, I may add that I also am appearing before you as a practicing physician of over 40 years experience, and still in active practice, to favor this proposed legislation.

Being a practicing physician I am in favor of all the provisions of this bill for expanding health personnel and facilities. But I am especially interested in title VII of this proposed legislation which is the heart of the program.

Over these many years of practice I have been impressed with the economic problems which have all too many times interfered with my own patients and the patients of my colleagues from obtaining ideal medical care. All thoughtful people will admit that in the United States the best of medical care in the world is available. Also, it is now generally agreed that this highest quality of medical care is not obtained by many of our citizens, and that those who do not obtain it are in both the rural and the urban areas. There are many factors involved in the problem of the failure of the delivery of medical care in certain instances. Unfortunately the number of people who do not receive satisfactory care for various reasons is distressingly large.

Ever since the Committee on the Costs of Medical Care in 1932 studied the problem of the poor delivery of medical care throughout the Nation, the reasons for the poor delivery and the methods to correct the faults have aroused considerable controversy, especially among members of the medical profession itself. Gradually over the years there has developed a general agreement in regard to the solution of many of these problems. Of the remaining problems the most important seems to be the justifiable high cost of good medical care for the individual. That high cost is justifiable is generally agreed by all. That those seeking preventive medical procedures can in most instances cover their expenses is probably true. It is certainly true, however, that the ill patients in many instances cannot cover the cost of diagnosis and treatment for important illness. Provision must be made, therefore, to provide for the cost of illness for those unfortunate enough to need care, and it is now generally agreed that the well must contribute.

It is generally agreed at the present time that the insurance method of spreading the cost is the most desirable, and the controversy has further narrowed down to the question of whether the insurance should be on a voluntary or a compulsory basis.

Voluntary insurance may be subdivided into profit insurance and nonprofit insurance. The nonprofit insurance managed by so-called organized medicine may be subdivided into insurance to be paid for entirely by the subscribers or to insurance in which Federal or State funds will be used to subsidize those who want the coverage and are not able to pay the premium rates.

It is generally conceded that millions of our population cannot pay the premium rates for so-called Blue Cross and Blue Shield coverage. It is further a well-established fact that Blue Cross and Blue Shield plans do not provide anything nearly equivalent to comprehensive medical care. Actually, bills have already been introduced in Congress to subsidize from Federal tax money those who are unable to join these inadequate medical-care programs. I think, therefore, it is fair at the present time to say that the controversy has narrowed down to whether the Congress will develop a national health program to be financed by compulsory health insurance such as is proposed in the bills before your committee to provide adequate medical care to most of our people, or shall favor the expenditure of Federal funds to help pay the premium rates for medical care which is far from adequate for those whom the "means tests" will show unable to pay.

The number of people who will need these Federal funds will reach into the many millions, and as the cost of medical care increases over the years, which is almost certain to be the case, the numbers will increase. In using Federal funds from tax money for this purpose the base from which these funds is collected is not broadened. Furthermore, there is no evidence that under these plans to continue charity medicine for millions of our people there will be any improvement in the amount of coverage offered by these voluntary plans. On the other hand, the program recommended in House bills 4312 and 4313 call for contribution from practically everyone, either employed or self-employed, and furthermore it is possible for the really indigent of each community to be included in the program if the local communities so desire. Thus the base from which the funds for the support of this program spring will be tremendously broadened. The amount of money so raised will depend upon how much the people through their representatives want to contribute for their health.

No program for the delivery of medical care should be considered by the Congress unless the quality of the medical care will be guaranteed to be good. It is my firm belief from experiences with existing voluntary prepayment plans controlled by organized medicine and from a study of the program proposed in the pending House bills that the quality of medical care will be on a much higher level in the proposed compulsory health insurance program, as judged by standards approved by organized medicine.

In the first place the compulsory health insurance program provides for preventive medical procedures and early diagnosis without extra expense to the individual. Neither of these very important elements in the delivery of good quality care are provided for in most voluntary insurance plans, and if provided for usually call for additional expense to the individual.

Next, millions of medically indigent people who at the present time have to accept charity medicine and who have no free choice of physician on this account will have an opportunity for the first time to have a family physician of his own choice. Should communities decide to participate in the plan for their really indigent these individuals will also have the same opportunity. Through the years organized medicine has insisted that the opportunity of free choice of physician is most important in obtaining good medical care, yet no such opportunity has existed over the years for the millions of our citizens forced to accept charity medicine.

Next, the proposed compulsory health insurance program provides that each patient will have his medical problems guided by the family physician of his own choice, and this physician will have without extra expense to the patient all needed laboratory facilities and opportunities to call in consultants without the problem of expense interfering between the patient and physician. Anyone with experience in the practice of medicine knows how important it is in guaranteeing good medical care to make sure that the medical problems of an individual are guided by the family physician who is acquainted with the patient's environment. The voluntary plans have not made provision to have the medical care of the subscribers guided by a family physician.

Next, one hears a good deal about the importance of there being no interference between the patient and physician in the guaranty of good quality medical care advanced by the supporters of voluntary health insurance plans. Yet it is generally admitted that the biggest barrier between the patient and the conscientious physician is the dollar. Certainly this proposed legislation for compulsory health insurance will eliminate the dollar barrier between the patient and the physician completely while the voluntary insurance plans eliminate it only a little, if any.

Finally, the quality of good medical care is guaranteed by the compulsory health insurance program because it insists on lay participation in the development of standards. The science of medicine belongs to the medical profession. The problem of the delivery of medical care belongs fully as much to the recipients of medical care as to the medical profession. It is of interest to realize that throughout the years higher standards in regard to the quality of medical care are formulated by lay boards of trustees than by organized medicine. In the voluntary insurance plans controlled by organized medicine, there is no restriction upon the activities of a physician in regard to what type of medical work he does other than his conscience. In our leading hospitals throughout the country lay boards of trustees guided by expert medical advice limit the activities of physicians on their staffs to what they are proven to be qualified to do. Therefore, my firm belief is that better quality medical care is guaranteed under the program in House bills 4312 and 4313 than in other proposed legislation which supports the growth of voluntary insurance plans controlled by organized medicine, which has repeatedly refused to control the activities of its members.

Among the important factors for the poor delivery of medical care to certain of our citizens is the lack of medical personnel and equipment in certain areas. Experience has shown that voluntary insurance plans have not attempted to provide equipment in areas where it is lacking nor tempted medical personnel to go into these areas. It is important to realize that in the program for compulsory health insurance provision is made to provide equipment to these needy areas and to make it attractive for medical personnel to settle in them. Thus again compulsory health insurance provides an extension of medical services to areas where needed which Blue Cross and Blue Shield plans developed by organized medicine have failed to do.

May I impose upon your time a few moments more to mention some other points which might be of interest to your committee.

Frequently I have been asked by my nonmedical friends why do not the doctors as a group insist on this compulsory health insurance program. The answer is simple: Many of them do; many others do not have a fair chance to evaluate the program because of the lack of freedom in the medical press which they read; I mean the Journal of the American Medical Association, and therefore, do not express themselves; many others are unalterably opposed because their minds have been influenced by the false propaganda spread throughout the country financed by the vast sums of money raised over the years by the now extinct National Physicians Committee; and finally there are many who prefer the existing situation in regard to the delivery of medical care, although they admit that in some areas it is unsatisfactory, but hope that it will eventually improve by the process of evolution.

Among the false statements made by its enemies in regard to title VII of the proposed national health program is one that the doctors would become regimented federal employees and have no professional freedom. Even a biased individual must admit the falsity of this claim. For the proposed legislation makes it clear that no physician must participate in the plan, and if he does he is free to decide for whom he will care. Furthermore, the proposed legislation calls for only the collection of funds and the establishment of rules to guarantee good quality care at the Federal level. The delivery of the care will be administered at the local level just as it is now, with complete freedom for the physicians provided they can deliver good quality care.

I trust that this last statement will also free the people from the fear of another great Federal bureaucracy (whatever that is) because to students of the proposed legislation it is obvious that the administration of the program is the responsibility of the local communities.

Perhaps I should not close without calling the attention of the committee to the recent boast of the American Medical Association that by an assessment of $25 upon all its members amounting to three and a half million dollars, which was made in an undemocratic manner and which the American Medical Association admits it has no authority to collect, the association hopes to defeat the enactment of a national health program to be financed in part by compulsory health insurance. When this boast was challenged by some of the members of the American Medical Association, the boast was changed by those in authority to the statement that the three and a half million fund, if collected, would be used for the education of the people on the value of President Truman's proposal for a national health program.

I think most educators of worth believe that on controversial subjects the claims of all sides should be presented fairly to help in reaching the best final decision.

May I humbly suggest that you watch for any fair presentation of this controversial subject in the Journal of the American Medical Association which claims that its three and a half million dollar fund will be used for education purposes.

Mr. PRIEST. Dr. Frothingham, may the Chair ask if it would be possible for you to return without too much inconvenience tomorrow morning?

Dr. FROTHINGHAM. I am afraid that I cannot do so tomorrow because I have important engagements in Boston.

Mr. PRIEST. Then, would it be possible for us to have you later on, say, around the 7th or 8th of June?

Dr. FROTHINGHAM. Yes.

Mr. PRIEST. The reason I make that request is that it is now necessary for the subcommittee to adjourn, there is a roll call in the House and we have a bill up for amendments shortly and it will be necessary to adjourn this session.

We were unable to anticipate this early session of the House when we set the hearing for today. So, if you care to do so, Doctor, I am sure the committee would be happy to have your full statement released in the record and then we could have you come back during the course of the hearings when convenient for you, so that you might answer any questions that the committee might have to ask.

Dr. FROTHINGHAM. That would be satisfactory to me.

Mr. PRIEST. Without objection, then, we will arrange for you to appear before the committee again at a later date if you are unable to do so tomorrow.

Without objection, the statement of Mr. Joseph Anderson of the American Association of Social Workers will be inserted in the record at this point.

(The statement is as follows:)

STATEMENT OF JOSEPH ANDERSON, EXECUTIVE SECRETARY OF THE AMERICAN ASSOCIATION OF SOCIAL WORKERS

THE NATURE OF OUR ORGANIZATION

The American Association of Social Workers is a national organization of professional social workers. It was founded 26 years ago and now has 11,500 members living in all parts of the United States and its territories. These social workers are employed in public and voluntary agencies at the local, State, national, and international levels. The association has about 100 chapters located in practically every State.

OUR RESPONSIBILITY

We believe that as a professional group we have a responsibility to make our considered opinion on health and medical care programs known to those who must decide upon national programs which will affect all of the citizens for years to come. We would like to express our appreciation for this opportunity to present our views on the legislative proposals embdied in H. R. 4312 and H. R. 4313. We will also comment on the proposals in other bills introduced into the Congress as "substitutes" for these two bills.

PLATFORM ON HEALTH AND MEDICAL CARE

For more than 10 years the association has been studying health needs and evolving the principles on which a national health and medical care program should be based. Our annual conference, attended by delegates chosen by each chapter, provides the chief means of formulating membership opinion on national issues. The annual delegate conference, last held in April 1948 in Atlantic City, N. J., adopted a "Platform on health and medical care." I am empowered to present the association's point of view on any national health legislation using the principles, which we adopted, as criteria.

OUR GENERAL POINT OF VIEW

The American Association of Social Workers believes that a national health program is an essential and integral part of a broad program of public social services. The physical and mental well-being of every person in the United States, its territories and possessions, is a concern of Government. A national health program must provide for the development and operation of social and health measures which must be related so as to assure continuity and integration of services. These must include preventive, diagnostic, treatment, convalescent, and chronic aspects of care and aim at rehabilitation, wherever possible.

Participation by the Federal Government and the States in the development and financing of a national health program is necessary to guarantee adequate and coordinated health and medical care of high quality, and general access to it. The consumers of health services should also participate in their development and financing through the channels of a comprehensive national contributory scheme of social insurance.

Facilities and services as well as benefits should be provided for all people in the United States as a matter of right, regardless of race, creed, citizenship, residence, and economic status.

With this general point of view in mind we have examined H. R. 4312 and H. R. 4313 and other proposals to see if they meet our standards on services and coverage of medical care.

SERVICES AND COVERAGE

Our platform states that a comprehensive program should provide integrated health, medical, and social services of good quality to all people everywhere in the United States. These services should be readily available under conditions in which the dignity of the individual is fully respected. Included should be complete and continuous care, preventive, diagnostic, therapeutic, according to the individual's social, medical, and nursing needs for as long as required. Also, there should be provision for correlation of public health, medical, surgical, psychiatric, dental, and nursing services, including all specialties.

H. R. 4312 and H. R. 4313 would establish a system of prepaid personal health insurance on the principle of social insurance. These bills provide complete medical services for employees, employed persons and the dependents of such persons. Also, State and local agencies may pay into the health insurance fund in behalf of others including the needy. H. R. 4312 and H. R. 4313 along with their companion bill, S. 1679, more nearly meet our criteria of services and coverage than other proposals.

H. R. 4312 and H. R. 4313 offer opportunities to the families in middle income brackets to pay for medical expenses while they are well and according to their incomes. Social workers know so well the situations of middle income families who can meet their needs until sudden illness strikes. For example, here is a man who earns $3,045 take-home pay a year in a local government position. His wife earns $1,433 as a teacher in a private school. They have a 6-year-old son. The wife was operated for an intestinal obstruction and had to be hospitalized three times in a 4-month period. Her medical bills are as follows:

Hospital bill	$306
X-ray and laboratory services	45
Private nursing	720
Medication	21
Total	1,092

The family went in debt to pay these. The wife has not yet received a bill from her private physicians and wonders how she will pay it. An additional expense has been $374 for a substitute at school, since she has been unable to work for a 4-month period. Unfortunately, this family had no protection against these medical costs. If they had had voluntary hospital and health insurance the annual premium would have been approximately $60 to $80 and would not have covered the largest item in this particular case, $720 for nursing, nor much of the physician's fees. Under national health insurance they would have had to pay no more than $72 a year for complete medical costs.

Many people still believe that voluntary plans can solve the problem of paying for medical care. Our experience with voluntary plans leads us to believe that they are inadequate to meet the problem. Most voluntary plans restrict their services, often not covering many illnesses or the full cost of needed medical care. The geographic limitations of these voluntary plans tend to limit the nature and scope of services in proportion to the income of the area. The actual record of voluntary plans in our country illustrates that although they perform a valuable service, they do not perform services of sufficient scope for enough people and for those who need the services most. Legislative proposals have been made to subsidize those voluntary plans in order that they might enroll persons unable to purchase voluntary insurance. Determination of eligibility of such persons inevitably requires a means test.

Social workers have probably had more experience with the means test than any other group in this country. We believe that it is demeaning to the individual. Also, it would serve as a deterrent to many families who would put off receiving medical care at a time when control of disease and/or prevention of disability are possible, or would deny themselves necessities, in order to keep from receiving medical charity, and thus endanger their health.

We have found that a means test is hard to administer in giving basic maintenance to people—shelter, food, household necessities, clothes, etc. It seems to us that a means test would be much more difficult to carry out in the complicated problems of medical care. Medical needs are sporadic and medical costs unpredictable. Perhaps a specific situation will illustrate this problem. Here is a family with take-home pay of $6,300 a year. We would not expect such a family to need medical care under ordinary circumstances. The husband makes $3,934 a year as a cost accountant on salary. The wife's annual income from her work as a technician is $2,366. There are three children, a girl 10, two boys, 8 and 6. Since the mother works, she has to pay for help in the home. The family has always carried hospital insurance. Six months ago the husband developed a kidney condition and has been hospitalized three times during this period. He has had two serious operations. Bills have been received for medical and surgical services amounting to $1,000. The husband's salary stopped when he became ill and this family of five has been attempting to live on the wife's take-home pay of $197 a month.

In this situation the family could meet ordinary medical needs and would probably be ineligible under a means test; however, we see that the costs of an extended and incapacitating illness in terms of medical bills and loss of income has precipitated an economic crisis in this family. In this instance as in thousands of others, we see the need for preventing such a tragedy.

We object not only to the means test but to any legislative proposals that would limit services to those given in hospitals and out-patient deparments. H. R. 4212 and H. R. 4213 not only cover hospitalized illness but provide services to patients in their homes and in physicians' offices, thus encouraging preventive care and relieving hospital beds. In the long run, this saves money for the insured and the government.

FINANCE

When we consider the financing of a program of health and medical care, we are committed to the following principles:

1. All basic health facilities and services should be financed by Government alone.

2. Government and contributory social insurance should provide jointly for the capital investment involved in the urgent expansion of free, low, and medium cost health centers and institutional facilities for diagnosis, treatment, rehabilitation, custodial care, and for research and professional education as related to the full development of the Nation's physical and mental health.

3. Grants-in-aid and loans for capital investment should be available for public and nonprofit private facilities of good standards.

4. Government and contributory social insurance should meet the operating cost of such facilities, if above their earnings derived from reasonable fees.

5. Reasonable fees for individual service—outside general preventative measures—should be covered by adequate benefits under a comprehensive social insurance scheme available to the insured and their dependents as a right.

6. Public funds, including those of social insurance should be administered by public agencies and disbursed to private agencies only for specific services rendered to the insured. Voluntary private agencies should not be made disbursing agents of public funds.

7. Government and social insurance funds—outside those needed for statutory benefits and services—should be allocated under conditions which would permit Government to equalize the burden of cost among the States, and within them.

FACILITIES AND PERSONNEL

We subscribe to the other titles of H. R. 4312 and H. R. 4313 providing for expansion of health facilities, education and training of health personnel, intensification of research, extension of public health services including maternal and child health care.

We approve especially of the provision for aid to rural and other shortage areas. These bills would encourage the development of group practice which we regard as a means of providing integrated and economical services. All these resources are essential to the successful operation of a comprehensive national health program. However, national health insurance is imperative to underwrite the costs of maintaining these expanded resources. In this way, only, can we achieve our goal of maximum health and well-being for every American.

CONCLUSION

In view of the above testimony we believe that our objective of making a full health program available to every citizen can be achieved largely through the national health insurance system proposed in H. R. 4312 and H. R. 4313, and, therefore, we endorse the proposed purposes, principles and philosophy of these measures.

Mr. PRIEST. The committee stands adjourned until 10 o'clock tomorrow morning.

(Thereupon, at 11:20 a. m., the subcommittee recessed to reconvene at 10 a. m. Wednesday, May 25, 1949.)

NATIONAL HEALTH PLAN

WEDNESDAY, MAY 25, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The committee will come to order.

When the committee adjourned yesterday, Dr. Channing Frothingham had just taken the stand. He remained over in order to complete his statement today and we will be happy to hear you at this time, Doctor.

Without objection, I think it would be in order for Dr. Frothingham to begin his statement at the beginning because the first part of it was interrupted yesterday, and proceed with the statement throughout.

If that is agreeable to you, Doctor, we will proceed in that way.

STATEMENT OF DR. CHANNING FROTHINGHAM—Resumed

Dr. Frothingham. Yes, Mr. Chairman. I will just reintroduce myself as appearing before this committee as chairman of the Committee for the Nation's Health, and as a practicing physician over the last 40 years, and still in practice.

The Committee for the Nation's Health is a committee composed of a cross section of the population and not representing any one group of the population. Then, I will go on from there and say that over these years of practice, I have been impressed with the economic problems which have all too many times interfered with my own patients and the patients of my colleagues from obtaining ideal medical care. All thoughtful people will admit that in the United States the best of medical care in the world is available. Also, it is now generally agreed that this highest quality of medical care is not obtained by many of our citizens, and that those who do not obtain it are in both the rural and the urban areas. There are many factors involved in the problem of the failure of the delivery of medical care in certain instances. Unfortunately the number of people who do not receive satisfactory care for various reasons is distressingly large.

Ever since the Committee on the Costs of Medical Care in 1932 studied the problem of the poor delivery of medical care throughout the Nation, the reasons for the poor delivery and the methods to correct the faults have aroused considerable controversy, especially among members of the medical profession itself. Gradually over the years there has developed a general agreement in regard to the solution of many of these problems. Of the remaining problems the most important seems to be the justifiable high cost of good medical care for the individual. That high cost is justifiable is generally agreed by all. That those seeking preventive medical procedures can in most instances cover their expenses is probably true. It is certainly true, however, that the ill patients in many instances cannot cover the cost of diagnosis and treatment for important illness. Provision must be made, therefore, to provide for the cost of illness for those unfortunate enough to need care, and it is now generally agreed that the well must contribute.

It is generally agreed at the present time that the insurance method of spreading the cost is the most desirable, and the controversy has further narrowed down to the question of whether the insurance should be on a voluntary or a compulsory basis.

Voluntary insurance may be subdivided into profit insurance and nonprofit insurance. The nonprofit insurance managed by so-called organized medicine may be subdivided into insurance to be paid for entirely by the subscribers or to insurance in which Federal or State funds will be used to subsidize those who want the coverage and are not able to pay the premium rates.

It is generally conceded that millions of our population cannot pay the premium rates for so-called Blue Cross and Blue Shield coverage. It is further a well-established fact that Blue Cross and Blue Shield plans do not provide anything nearly equivalent to comprehensive medical care. Actually, bills have already been introduced in Congress to subsidize from Federal tax money those who are unable to join these inadequate medical-care programs. I think, therefore, it is fair at the present time to say that the controversy has narrowed down to whether the Congress will develop a national health program to be financed by compulsory health insurance such as is proposed in the bills before your committee to provide adequate medical care to most of our people, or shall favor the expenditure of Federal funds to help pay the premium rates for medical care which is far from adequate for those whom the "means tests" will show unable to pay.

The number of people who will need these Federal funds will reach into the many millions, and as the cost of medical care increases over the years, which is almost certain to be the case, the numbers will increase. In using Federal funds from tax money for this purpose the base from which these funds is collected is not broadened. Furthermore, there is no evidence that under these plans to continue charity medicine for millions of our people there will be any improvement in the amount of coverage offered by these voluntary plans. On the other hand, the program recommended in House bills 4312 and 4313 call for contributions from practically every one, either employed or self-employed, and furthermore it is possible for the really indigent of each community to be included in the program if the local communities so desire. Thus the base from which the funds for the support of this program spring will be tremendously broadened. The amount of money so raised will depend upon how much the people through their representatives want to contribute for their health.

No program for the delivery of medical care should be considered by the Congress unless the quality of the medical care will be guaranteed to be good. It is my firm belief from experiences with existing voluntary prepayment plans controlled by organized medicine and from a study of the program proposed in the pending House bills that the quality of medical care will be on a much higher level in the proposed compulsory health-insurance program, as judged by standards approved by organized medicine.

In the first place the compulsory health insurance program provides for preventive medical procedures and early diagnosis without extra expense to the individual. Neither of these very important elements in the delivery of good quality medical care are provided for in most voluntary insurance plans, and if provided for usually call for additional expense to the individual.

Next, millions of medically indigent people who at the present time have to accept charity medicine and who have no free choice of physician on this account will have an opportunity for the first time to have a family physician of their own choice. Should communities decide to participate in the plan for their really indigent these individuals will also have the same opportunity. Through the years organized medicine has insisted that the opportunity of free choice of physicians is most important in obtaining good medical care, yet no such opportunity has existed over the years for the millions of our citizens forced to accept charity medicine.

Next, the proposed compulsory health insurance program provides that each patient will have his medical problems guided by the family physician of his own choice, and this physician will have without extra expense to the patient all needed laboratory facilities and opportunities to call in consultants without the problem of expense interfering between the patient and physician. Anyone with experience in the practice of medicine knows how important it is in guaranteeing good medical care to make sure that the medical problems of an individual are guided by the family physician who is acquainted with the patient's environment. The voluntary plans have not made provision to have the medical care of the subscribers guided by a family physician.

Next, one hears a good deal about the importance of there being no interference between the patient and physician in the guaranty of good quality medical care advanced by the supporters of voluntary health insurance plans. Yet it is generally admitted that the biggest barrier between the patient and the conscientious physician is the dollar. Certainly this proposed legislation for compulsory health insurance will eliminate the dollar barrier between the patient and the physician completely while the voluntary insurance plans eliminate it only a little, if any.

Finally, the quality of good medical care is guaranteed by the compulsory health insurance program because it insists on lay participation in the development of standards. The science of medicine belongs to the medical profession. The problem of the delivery of medical care belongs fully as much to the recipients of medical care as to the medical profession. It is of interest to realize that throughout the years higher standards in regard to the quality of medical care are formulated by lay boards of trustees than by organized medicine. In the voluntary insurance plans controlled by organized medicine, there is no restriction upon the activities of a physician in regard to what type of medical work he does other than his conscience. In our leading hospitals throughout the country lay boards of trustees guided by expert medical advice limit the activities of physicians on their staffs to what they are proven to be qualified to do. Therefore, my firm belief is that better quality medical care is guaranteed under the program in House bills 4312 and 4313 than in other proposed legislation which supports the growth of voluntary insurance plans controlled by organized medicine, which has repeatedly refused to control the activities of its members.

Among the important factors for the poor delivery of medical care to certain of our citizens is the lack of medical personnel and equipment in certain areas. Experience has shown that voluntary insurance plans have not attempted to provide equipment in areas where it is lacking nor tempted medical personnel to go into these areas. It is important to realize that in the program for compulsory health insurance provision is made to provide equipment to these needy areas and to make it attractive for medical personnel to settle in them. Thus again compulsory health insurance provides an extension of medical services to areas where needed which Blue Cross and Blue Shield plans developed by organized medicine have failed to do.

May I impose upon your time a few moments more to mention some other points which might be of interest to your committee.

Frequently I have been asked by my nonmedical friends why do not the doctors as a group insist on this compulsory health insurance program. The answer is simple: Many of them do; many others do not have a fair chance to evaluate the program because of the lack of freedom in the medical press which they read; I mean the Journal of the American Medical Association, and therefore, do not express themselves; many others are unalterably opposed because their minds have been influenced by the false propaganda spread throughout the country financed by the vast sums of money raised over the years by the now extinct National Physicians Committee; and finally there are many who prefer the existing situation in regard to the delivery of medical care, although they admit that in some areas it is unsatisfactory, but hope that it will eventually improve by the process of evolution.

Among the false statements made by its enemies in regard to title VII of the proposed national health program is one that the doctors would become regimented Federal employees and have no professional freedom. Even a biased individual must admit the falsity of this claim. For the proposed legislation makes it clear that no physician must participate in the plan, and if he does he is free to decide for whom he will care. Furthermore, the proposed legislation calls at the Federal level for only the collection of funds and the establishment of rules to guarantee good quality care at the Federal level. The delivery of the care will be administered at the local level just as it is now, with complete freedom for the physicians provided they can deliver good quality care.

I trust that this last statement will also free the people from the fear of another great Federal bureaucracy—whatever that it—because to students of the proposed legislation it is obvious that the administration of the program is the responsibility of the State and the local communities.

Perhaps I should not close without calling the attention of the committee to the recent boast of the American Medical Association that by an assessment of $25 upon all its members amounting to 3½ million dollars, which was made in an undemocratic manner and which some State societies admit has no authority to collect, the association hopes to defeat the enactment of a national health program to be financed in part by compulsory health insurance. When this boast was challenged by some of the members of the American Medical Association, the boast was changed by those in authority to the statement that the 3½-million fund, if collected, would be used for the education of the people on the value of President Truman's proposal for a national health program.

I think most doctors of worth believe that on controversial subjects the claims of all sides should be presented fairly to help in reaching the best final decision.

May I humbly suggest that you watch for any fair presentation of this controversial subject in the Journal of the American Medical Association which claims that its 3½ million dollar fund will be used for education purposes.

Thank you.

Mr. Priest. Thank you, Dr. Frothingham.

Under the terms of title VII in the bill, as you emphasize in your statement, a physician is free to decide whether he will participate in the plan if it should be approved by the Congress and it becomes the law.

You are a practicing physician and have been for 40 years. I assume that if such a plan were approved you would decide to participate?

Dr. Frothingham. I would like to very much; yes.

Mr. Priest. On that assumption, and your answer that you would, I wonder if you would just very briefly tell the committee what, in your opinion, would be the effect on your present practice with your regular patients if this bill should be enacted and you decided to participate; what change would there be, if any, in the relationship that you have with your regular patients at this time? Just how would it affect that relationship and your practice?

Dr. Frothingham. There would be no change in the relationship, except my revenue would come from another source, and I would be sure of getting it. Also if I had a patient about whose finances I was somewhat in doubt, I would feel at liberty to give that patient better medical care, because I would not have to worry about the patient's pocketbook.

Mr. Priest. Are there any other questions?

Mr. O'Hara. Yes, I would like to ask the doctor some questions.

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. Doctor, is it your position that this is a good guaranty for the doctor's pay; is that the theory that you support this program upon?

Dr. Frothingham. I certainly do not support it only on that basis. I think it will make a great many doctors receive a more stable income, but I am working on this program to see that the people get good medical care.

Mr. O'Hara. Well, you indicated in your statement—I believe I quote your correctly—that one of the large barriers between the doctor and his patient is the dollar; is that correct?

Dr. Frothingham. Yes.

Mr. O'HARA. You mean by that that the doctor does not treat or prescribe for the patient if he does not have the money to pay?

Dr. FROTHINGHAM. Certainly not. Then they become charity medical cases.

I mean that, suppose you have a cough and I am not quite certain what your income is, and I do not want to subject you to unnecessary expense; I might guess whether you had pneumonia, because I do not want to subject you to the expense of an X-ray. Under this program without worrying about your pocketbook, I would have an X-ray taken.

Mr. O'HARA. Well, of course, Doctor, is it not true that doctors do treat patients who do not have the money to pay for the treatment?

Dr. FROTHINGHAM. Yes, indeed. We take care of the real indigent and we take care of the medical indigent without having them pay anything—millions of them. There are 10 medical indigent, almost, to 1 indigent in our community; take a hospital like the Massachusetts General.

Mr. O'HARA. Well, that, I presume, deals principally with those who are indigent; is that not true?

Dr. FROTHINGHAM. I think we must have a clear understanding between indigent and medical indigent. An indigent person is one who has very little if any income. I may be wrong about that. Medical indigent person is a person who perhaps has bread and butter and perhaps an automobile; often comes to the hospital in a taxicab, but they do not pay for their medical care, because they are so-called medical indigents. Those people outnumber, in our community, at least 10 to 1, the indigents.

Mr. O'HARA. What percentage of the people of the United States would you say are able to pay for their medical care? I mean ordinary medical care. I do not mean in cases of protracted sickness, because I do not know whether anybody has enough money, unless he is a millionaire, to care for that.

Dr. FROTHINGHAM. I would not have those figures. They are easily obtainable.

Mr. O'HARA. I saw some figures on the English situation in which it was estimated that 80 percent of the people of England earned less than $2,000 a year. Whether those are correct or not, I do not know. I have no way of knowing, Doctor.

But certainly that would not be true to the same extent in this country, would it?

Dr. FROTHINGHAM. Well, I do not think I am competent to answer that question. I really do not know much about that.

Mr. PRIEST. Will the gentleman from Minnesota yield?

Mr. O'HARA. I would be happy to yield.

Mr. PRIEST. On the same subject, I wonder if it would be your opinion, Doctor, that the percentage throughout the Nation would be somewhat in line with the ratio you mention as applies in Boston of 10 to 1: 10 medical indigent to 1 indigent?

Dr. FROTHINGHAM. I think that is true. Then, I think it is also fair to say that you are certainly making the upper bracket big, if you say 20 percent of the people can pay for their medical care and some of my statistical friends tell me only about 10 or 15 percent can pay for medical care if it amounts to anything.

Mr. O'Hara. With reference to indigent and medical indigent, what is the distinction? Is it that one does not want to pay and the other wants to and cannot; is that the distincion?

Dr. Frothingham. The indigent are the people on welfare, and I understand they have no wealth. The medical indigent is a fellow who has, by the means test, been able to satisfy the facts that he is not indigent and then somewhere along the line of those millions of people they come to the stage where they just cannot pay the doctor; cannot have a doctor of their own choice to go to and have to go to the clinic.

Mr. O'Hara. Do you think this bill would take care of that? I mean, the only compulsory part is between the employer and the employee. Is that not true? Is not that true in this bill, Doctor?

Dr. Frothingham. My impression of the bill is that everybody who is employed or anybody who makes some money, with certain limitations, has to contribute, and thereby a fund of money is raised out of which medical care is provided.

Mr. O'Hara. Do you know what amount will be raised under the provisions of the bill?

Dr. Frothingham. No. There you are getting into figures I do not understand.

Mr. O'Hara. Do you have any idea what the cost of administering this will be, Doctor?

Dr. Frothingham. Again, I do not know that, but I would say this: That if we have 48 voluntary health insurance plans, all managed independently, it will cost a great deal more than one over-all plan managed as one plan; and we may have, on a voluntary insurance system, more than 48 plans, because in some of the States there are already more than one plan.

Mr. O'Hara. Do you anticipate that the fees of the doctors would be increased, if this bill is enacted, for the same treatment?

Dr. Frothingham. If you adopt the bill with the modifications that I would put in, you would eliminate fees for services entirely. There would be perpetual haggling if you have fees for services in the program as to what the fees will be.

The fees paid now for services under the Blue Shield program are generally less than the doctors get when they send out their personal bills, but that varies tremendously, because one doctor charges differently than another.

Mr. O'Hara. And I suppose there is a great deal of difference between the charges of the specialist, the rural doctor, and the urban doctor. Is that not true?

Dr. Frothingham. I think it is fair to say there is a good deal of variation in fees in the profession at the present time.

Mr. O'Hara. That is all I have.

Mr. Biemiller. Mr. Chairman.

Mr. Priest. Mr. Biemiller.

Mr. Biemiller. Doctor, you referred in the course of your testimony to two facts, first, that you represented the Committee for the Nation's Health, and secondly, you made certain references to the policies of the American Medical Association.

In the first of those matters, can you give us for the record the names of the officers of the Committee for the Nation's Health?

Dr. Frothingham. The last time I appeared before the committee I could not remember names, so this time I fortified myself with a list. If I may read it.

Mr. Biemiller. Yes, Doctor.

Dr. Frothingham (reading):

Committee for the Nation's Health

Chairman, Channing Frothingham, M. D.

Honorary vice chairman, Gov. Chester Bowles.

Jonathan Daniels
Russell Davenport
William Green
Bishop Francis J. McConnell
Philip Murray
Bishop G. Bromley Oxnam
Mrs. Franklin D. Roosevelt
David Sarnoff
Gerard Swope

Treasurer, Carl C. Lang

Secretary, V. Henry Rothschild 2d

Chairman Executive Committee, Michael M. Davis

Board of Directors

Channing Frothingham, M. D.
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Mrs. Gardner Cowles
Michael M. Davis
Albert W. Dent
Abe Fortas
Mary Dublin Keyserling
Carl C. Lang
Mrs. Albert D. Lasker
John V. Lawrence, M. D.
Mrs. Adele Levy
Mrs. Florence Mahoney
Dorothy Norman
Eric Peterson
Emil Rieve
Anna M. Rosenberg
V. Henry Rothschild 2d
Robert F. Wagner, Jr.
R. M. Walls, D. D. S.
Hubert Will
Mathew Woll

Executive Director, Chat Paterson

Public Relations Director, Nathan Robertson

Legislative Representative, Margaret Stein.

I would like to just state, if I might, that there is a possibility that there may be one or two changes in names because we did have our annual meeting just a month or so ago, and there might have been resignations or additions.

Mr. Biemiller. This list substantiates your contention that it is a cross section of various economic elements in our country; labor, professions, businessmen, et cetera?

Dr. Frothingham. Yes, sir.

Mr. Biemiller. Now, on the question of the policies of the American Medical Association, have you yourself at any time been an officer of any of the county or State or city bodies of the American Medical Association?

Dr. Frothingham. I was president of the Massachusetts Medical Society for two terms.

Mr. Biemiller. What is the relationship between the county societies, the State societies, and the American Medical Association?

Dr. Frothingham. Is your question just a State society, without the counties, or the counties and the State?

Mr. Biemiller. Pardon me?

Dr. Frothingham. Just the counties and State, or just State?

Mr. Biemiller. I will start first with the relationship between the county and State, if any, and the National and State.

Dr. Frothingham. We have the State divided into counties or districts, and then they organize and have their State society, and then from the State society, delegates are sent to the house of delegates of the American Medical Association.

Mr. Biemiller. The house of delegates of the American Medical Association is then composed of delegates elected by conventions to the State medical society?

Dr. Frothingham. That is right.

Mr. Biemiller. And the State medical society conventions are made up of delegates from the county medical societies?

Dr. Frothingham. That is right.

Mr. Biemiller. What is the basis of eligibility for membership in the county medical society?

Dr. Frothingham. You have to be a registered physician; you have to have graduated—I am talking now about Massachusetts—you have to have graduated from a so-called class A or recognized medical school, in addition to passing the examination for registration, you also have to pass an examination of what they call a board of censures, I think it is, of the county society.

Mr. O'Hara. Will the gentleman yield?

Mr. Biemiller. Yes; I will yield to the gentleman.

Mr. O'Hara. Doctor, I assume he has to be a citizen of the United States?

Dr. Frothingham. I should guess so, but there again I would not be sure.

Mr. Biemiller. That part would probably be covered by the statute of the State, covering the eligibility of those taking the examination.

Dr. Frothingham. I presume so.

Mr. Biemiller. In my State, the statute provides, for example, that a man cannot even take the examination unless he has graduated from an American medical school of recognized standing.

Now, do I understand correctly that the only dues that a doctor pays are paid to the county medical society?

Dr. Frothingham. No. That, again, will vary in different States. My impression is that the only dues I pay in Massachusetts are to the Suffolk County medical group. I am not sure whether I pay anything in addition to the Massachusetts Medical Society.

Mr. Biemiller. You pay no dues to the American Medical Association, as such?

Dr. Frothingham. I pay tribute by subscribing to the Journal.

Mr. Biemiller. But there are no dues, as such?

Dr. Frothingham. No.

Mr. Biemiller. From an individual member of the American Medical Association?

Dr. Frothingham. That is right.

Mr. Biemiller. The American Medical Association, then, is this house of delegates which, in turn, elects the officers of the American Medical Association?

Dr. Frothingham. Yes.

Mr. Biemiller. You state that the American Medical Association Journal has not given the doctors of the country any opportunity to read the case in the Journal, for compulsory health insurance?

Dr. Frothingham. They have never published anything that my groups have presented.

Mr. Biemiller. I once made the statement that I thought that Dr. Fishbein, as editor of the American Medical Association Journal, had thrown an iron curtain around it so far as arguments in favor of compulsory health insurance were concerned.

Do you think that is an accurate statement in the terms of your experience?

Dr. Frothingham. I do not think I ought to criticize Dr. Fishbein, because at the meeting in North Carolina last year, he said "Any position Frothingham takes is senile impudence."

Mr. Biemiller. Of course, Dr. Fishbein is well known as having one of the glibbest tongues in the United States, so I am not surprised at anything coming from him.

But, Doctor, definitely, then, we can take from your testimony and your answers, that in your opinion doctors have never had an opportunity to read in the pages of the Journal of the American Medical Association a reasonable case for compulsory health insurance?

Dr. Frothingham. That is right.

Mr. Biemiller. So that a doctor who gains most of his knowledge from the pages of the American Medical Association Journal could remain blissfully ignorant of any arguments that are being made from time to time by the proponents of compulsory health insurance?

Dr. Frothingham. If ignorance is bliss; yes.

Mr. Biemiller. That is all, Mr. Chairman.

Mr. Priest. Mr. Gillette.

Mr. Gillette. I have no questions.

Mr. Priest. Mr. Wilson.

Mr. Wilson. Yes, Mr. Chairman.

Doctor, you have been a practicing physician for many, many years, so I understand from your testimony.

Dr. Frothingham. Yes.

Mr. Wilson. I would like to get down to a case in connection with the evidence thus far before this committee.

There have been statements that there have been retaliations and punishments meted out to the practicing physicians because they dared to express their personal opinions.

In the testimony before the committee thus far, there have been two incidents, one in Louisiana and one in Arkansas.

What has been your experience? Have you had any retaliation against you personally as a physician, a practicing physician, along that line.

Dr. Frothingham. I do not think locally they think I am worth retaliating on; but I do hear from my colleagues in other parts of the country that they are with me in spirit in this fight, or whatever you want to call it, but they do not dare say so out loud for fear they would be retaliated against in their local communities.

Mr. Wilson. You spoke in your testimony about the assessment of $25 per individual member as having been collected in an undemocratic manner.

Dr. Frothingham. Having been assessed undemocratically.

Mr. Wilson. Yes; I so understood your statement to mean the words "assessed in an undemocratic manner."

Dr. Frothingham. That is what I mean to say.

Mr. Wilson. Were you one of the contributors?

Dr. Frothingham. I have not contributed.

Mr. Wilson. Did you protest it?

Dr. Frothingham. I am pretty sure that I put some sort of letter in the New England Journal of Medicine. I would have to check on that. But we certainly have protested it informally, and I think we have asked formally whether the members of the Massachusetts Medical Society had to pay it, and we finally succeeded in getting a statement from those in authority in the Massachusetts Medical Society that the members do not have to pay. But, remember, that is Massachusetts. Some of the States have made it compulsory to pay.

Mr. Wilson. If my memory serves me correctly, the press carried a statement about some 150 or 200 doctors having protested the method in which the assessment was to be made.

Dr. Frothingham. That is right. That is another group of physicians that I highly respect. I know most of them personally. I do not happen to be on that list. I thought I was enough of a troublemaker on the list I am on.

Mr. Wilson. Well, do you have any personal knowledge of retaliation or punishment to be meted out to individual doctors for expressing their individual opinions?

Dr. Frothingham. I think I could find them in my files. I do not have them at the end of my tongue, but I am pretty sure we can get evidence along that line if desired.

Mr. Wilson. Thank you.

Mr. Priest. Mr. Bennett.

Mr. Bennett. Doctor, under this bill, would the doctors' fees be set for every particular kind of ailment. I mean, would they be uniform for every particular type of service?

Dr. Frothingham. The bill provides for three methods of payment and the doctors in the community may decide how they want it, and if the majority of the doctors in the community want one thing, and an individual doctor wants another method of payment, that is also permitted.

Now, getting down to the community or the local area where the doctors want to be paid on the fee-for-service basis, then there would be fees set, I imagine, probably at a fairly uniform level, except that it would be considered that a specialist would be entitled to a higher fee than a man who was not quite as well educated along some special line. There will be an attempt, of course, to try to see that specialism is defined. Specialism is very hard to define, because in some communities there are no specialists.

Mr. Bennett. Would the word "specialist" be defined in the bill or law, or would some board, local or Federal, define it?

Dr. Frothingham. The definition of "specialism" is a very difficult problem in American medicine today. Some people think it should be defined by legislation. Other people think it should be defined by education. There are several groups throughout organized medicine that try to define specialism at the present time and as the years roll by "specialism" is being more and more defined.

Mr. Bennett. Well, I realize that; but what I mean is, what changes will this law make in the determination of who is a specialist in medicine and who will make that determination?

Dr. FROTHINGHAM. At the present time, I do not think this law is going to make any change. I do not think it has tackled that problem yet. I think that problem would be tackled by a group of laymen and physicians combined.

Mr. BENNETT. Is there anything in this bill which changes the present set-up?

Dr. FROTHINGHAM. I do not think so. You mean, the practice of medicine?

Mr. BENNETT. Well, for determining who, for example, is a specialist in the field?

Dr. FROTHINGHAM. I do not think so.

Mr. BENNETT. That would remain the same as it is now?

Dr. FROTHINGHAM. I think so.

Mr. BENNETT. But, suppose, under this bill, in a given community, that a certain doctor charges $150 to take out the appendix, and the average doctor charges $75 or $100.

Now, under this bill, I am wondering if the doctor I want, who charges $150 and is my doctor, if under this bill I can go to him and he can receive $150 for taking out my appendix?

Dr. FROTHINGHAM. The fee will be set for taking out an appendix by the group of doctors in that community. Now, if the group of doctors in that community have bargained with the Government and decided that an appendicitis operation is going to be paid for at $100, from the general fund, you want to go to your doctor, if you want to give him an extra $50, why, you can do it, but you cannot raid the fund.

Mr. BENNETT. Well, can the doctor ask $150 and collect it?

Dr. FROTHINGHAM. He can ask for it. We ask for things lots of times; we ask for more than we get in the practice of medicine.

Mr. BENNETT. I mean, under the bill, will it be a local medical group getting together and setting a list of fees, or will somebody set it up under this bill, local or otherwise, set the fees; or will a board of doctors set the fees? Just how is that going to be worked out?

Dr. FROTHINGHAM. I think probably the details are not too clear in my mind, but I am of the opinion and my impression on the plan is that there will be bargaining between those who hold the purse strings of the fund and the doctors in the local community.

Mr. BENNETT. Doctor, those who hold the purse strings of the fund will have the final say; will they not?

Dr. FROTHINGHAM. I say that I am not actually familiar with workings.

Mr. BENNETT. Would you subscribe to that kind of plan, in other words, where a local board or a Government board sets it up under this bill and would have the power to fix medical fees in every type of case and make them uniform?

Dr. FROTHINGHAM. As I have already said, I do not approve of fees for services in medicine. I think that is the weakest part of American medicine today.

Now, if we are going to have fees for services, then the only guess we can make is that it will be fashioned something on the program of the voluntary-insurance plans; and the voluntary-insurance plans, which certain people seem to favor, have the fees organized by an arrangement between the insurance company and the medical profession.

Mr. BENNETT. Yes, but the doctor under Blue Cross and Blue Shield charges whatever he pleases. He is allowed a certain fee under the Blue Cross; but, as far as the patient is concerned, he may charge whatever fee he wishes to charge. Is that not true?

Dr. FROTHINGHAM. I think you are a little bit confused. I do not mean to be rude.

In the first place, the Blue Cross does not have anything to do with the doctor's fee. That is hospital work.

The Blue Shield; yes, in the Blue Shield.

Mr. BENNETT. What I am talking about is the plan that applies to certain treatment.

Dr. FROTHINGHAM. That is the Blue Shield.

Mr. BENNETT. All right.

Dr. FROTHINGHAM. Now, that varies in every State. There is no national Blue Shield system.

Mr. BENNETT. Yes; but is it not a fact that, regardless of what the Blue Shield says, the doctor can charge any fee he wants to charge?

Dr. FROTHINGHAM. I am coming to that, sir. In Massachusetts, if you are in a certain income level, the doctor cannot charge anything beyond what he gets from the Blue Shield. If you happen to be beyond a certain income level and pass the means test, then the doctor may charge you in addition to what the Blue Shield pays you, but that, again, is limited as to how far beyond the means test and what group you come in through the means test.

Mr. BENNETT. Is that set by Massachusetts law or is that by agreement with the medical profession?

Dr. FROTHINGHAM. That is by agreement with the medical profession.

Mr. BENNETT. Now, on page 4 of your statement, you say:

> In the voluntary-insurance plans controlled by organized medicine, there is no restriction upon the activities of a physician in regard to what type of medical work he does other than his conscience—

intimating that would be changed under this proposed legislation.

Dr. FROTHINGHAM. Yes, sir.

Mr. BENNETT. Will you explain a little more in detail what you mean by that?

Dr. FROTHINGHAM. I think I can put it simply, this way: I think I am a pretty good doctor; I was chief of the medical service of the Fortner Hospital in Boston. I am participating in the Blue Shield plan in Massachusetts.

According to the rules of that Blue Shield plan made by the medical profession and the Fortner Hospital, I can do any type of medicine. Under the rules of the Fortner Hospital made by the lay board of trustees, under advice from expert doctors, I am not allowed to open a boil or deliver a baby. I am only allowed to do internal medicine, which I am supposed to be qualified to do.

As I said, in my statement, lay participation in the making of the rules that have developed over the years has resulted in higher standards in regard to the quality of care than the standards made by organized medicine.

Mr. BENNETT. And you mean, by that, that under this bill some group of laymen will set up the standards by which physicians may practice and specialize?

Dr. FROTHINGHAM. They are going to set up general rules for the guidance of the quality, control of the quality of care; not just a group of laymen alone, but a combination of lay and medical men, and that group of laymen and medical men which we see on our boards of trustees throughout this country has always made better quality rules than just organized medicine alone.

Mr. BENNETT. Well, in order to be a specialist, after this law goes into effect, a man will have to be designated as such by some board created under the law?

Dr. FROTHINGHAM. I hope so. I think one of the weakest parts of American medicine today is some fellows posing as specialists and learning how to become specialists on private patients for a big fee.

Mr. BENNETT. I think that is all.

Mr. SCOTT. Mr. Chairman.

Mr. PRIEST. Mr. Scott.

Mr. SCOTT. Dr. Frothingham, did I understand you to say to Mr. Bennett that, under this new trend—"blue-sky plan," I call it, as against the Blue Shield plan, that if the doctors in a given area elect the fee bases, those fees will be fixed in the amount that any doctor could charge for an appendectomy. Is that right?

Dr. FROTHINGHAM. I do not think that they would be fixed. A doctor could try to get just as much as the traffic would bear, but they would only be able to raid the treasury for the fee that has been decided. Suppose I am a surgeon under the plan and the plan calls for $100 and you want me. I do not have to take you as a patient unless I want to. And I can say that I will get $100 from the fund and then I would like $100 more out of your pocket.

Mr. SCOTT. But you are only entitled to a legal raid on the treasury in the amount of $100, and then the raid on the patient's purse in the amount of $100.

Dr. FROTHINGHAM. You do not need to raid the patient's purse at all.

Mr. SCOTT. But you are entitled to a legal raid on the treasury for $100; is that right?

Dr. FROTHINGHAM. If the fee is fixed; yes.

Mr. SCOTT. I see now; the physician is not entitled to any more, so if instead of just finding a little teeny-weeny appendectomy, taking a few minutes of the physician's time, then he would be entitled to receive the same amount as if the appendectomy were complicated and other matters involved: I do not know what your expert phraseology is, but if it is involved, I think you refer to it as some pleural infection.

Dr. FROTHINGHAM. Well, say "peritonitis" if it is in the abdomen.

Mr. SCOTT. No matter how many additional hours' time and attention a patient might require and the doctor might be required to give, he would not be entitled to receive any more; in that respect he would differ from members of all other organizations and associations, would he not?

Dr. FROTHINGHAM. I do not admit that your statement is accurate, because, at the present time, provision is made for just that sort of thing in these Blue Shield programs.

Mr. SCOTT. I am speaking not of the Blue Shield, but the blue-sky program.

Dr. Frothingham. Well, so far as we know, if we go on a scheduled basis, the blue sky will be just the same as the Blue Shield in the way they work out the fee schedule, because it is worked out in conjunction with medical men.

Mr. Scott. But under that blue-sky plan, they could not raid anybody for more than the fixed amount, no matter how much they worked, could they?

Dr. Frothingham. Why, yes.

Mr. Scott. So that an ordinary doctor would have the same pay as all others would have?

Dr. Frothingham. Don't try to ask me a question and then answer it, because you are answering it the way that I would not answer it.

Mr. Scott. I will be glad to have your answer.

Dr. Frothingham. If you would ask me a question and then stop so I can answer it, I will be glad to try to answer it.

Mr. Scott. Well, I have not heard your answer.

Dr. Frothingham. I have not heard the question.

Mr. Scott. The question, I will repeat, Under the blue-sky program, as I understand it from you, there can be no additional raid on the Treasury and no legal charge against the patient's purse, for an appendectomy above a certain fixed amount, no matter how much work the doctor may have to do.

Dr. Frothingham. That is not so.

Mr. Scott. Is that so?

Dr. Frothingham. That is not so.

Mr. Scott. The question is, Is that so?

Dr. Frothingham. That is not so.

Mr. Scott. My next question is, Why is it not so?

Dr. Frothingham. Because you have got two points there. You have got the question of raiding the Treasury and then you are bringing up the question, Has a doctor any legal right to any fee, or any more than that out of the patient's pocket? And that is quite different; that has nothing to do with the bill.

If I take out your appendix, I get $100 from the Treasury. If I also make a dicker with you that I will not take it out unless I get something out of your pocket, that is something else.

Mr. Scott. By the way, Doctor, you made one statement that I am sure we all agree to. You said, "I think I am a pretty good doctor."

Under the blue-sky plan, would that make any difference in the charges?

Dr. Frothingham. If I posed as a specialist in internal medicine, I would have a specialist's fees, and specialists' fees will have to be organized on a different basis from general practitioners' fees, and if they are on a salary basis the specialist will get perhaps a higher salary than the general practitioner, because he would not have so much work.

Mr. Scott. Well, let us assume that we have a general practitioner treating perhaps 5,000 cases in his life, involving a certain kind of a virus infection, and a young physician with 3 to 5 cases. Under this bill, there would be no means by which the older practitioner could receive any more than one who was just beginning. Is that correct?

Dr. Frothingham. No; because if I had had that many cases, I would probably be a specialist in virus diseases, and the bill provides, without extra expense to the patient, the opportunity for the family physician to call in the specialist.

Mr. Scott. Suppose you had not held yourself out as a specialist. Then you could make no difference in your charges.

Dr. Frothingham. I do not believe I would be worth it.

Mr. Scott. I guess we would have to accept your answer, Doctor.

Mr. Priest. Are there any further questions?

Mr. O'Hara. Yes; I would like to ask the doctor a question.

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. Doctor, I am a little troubled about this phase of this bill. If we assume this bill becomes law, it does not change the very important equation of the man going to the doctor whom he wants to go to. Is that not true?

Dr. Frothingham. Not only does not change it as to those who have the privilege of going to the doctor they want to go to now, but gives the opportunity to millions of our population who do not have it now.

Mr. O'Hara. Well, the average person who becomes ill goes to a doctor whether he likes to go or not; is that not true?

Dr. Frothingham. Some go to the osteopaths and chiropractors.

Mr. O'Hara. But the point that I am getting at is, the confidence that the patient has in the doctor is oftentimes as important as the skill of that doctor himself or what he prescribes for that patient.

Dr. Frothingham. That is right.

Mr. O'Hara. That is true, is it not?

Dr. Frothingham. That is right.

Mr. O'Hara. Now, if this plan goes into effect; let us just take an assumed case. You feel you are a specialist; you say, "Well, I do not want to go under the plan. I do not like to go under the plan. I want to have some right of picking or turning down my patients. I do not enjoy working with a patient or I feel I am not going to do a good job for him; I would not want that man," maybe.

Dr. Frothingham. Of course, you have that opportunity under the plan. You understand that.

Mr. O'Hara. Suppose I have a very bad gall-bladder condition and I have great confidence in you as a surgeon, and I go to you and I say, "Doctor, I haven't any money. I want to come in under this insurance, this national health insurance plan. I want you to take my gall bladder out."

Now, you say, "Well, I am sorry. I have not joined as a doctor. I cannot take your case."

Well, now, what happens to me? That does something to me. I have to go to some doctor I do not know, I do not have any confidence in, and say, "Doctor, I guess you will have to operate on me." Is not that the situation you have?

Dr. Frothingham. I do not think so. I think it is just the reverse.

Mr. O'Hara. Well, you cannot compel a doctor to go in under this plan, can you?

Dr. Frothingham. No.

Mr. O'Hara. I mean, this plan does not say every doctor has to operate on the basis of the Government saying so?

Dr. Frothingham. No. It does not say that.

Mr. O'Hara. It does not say so?

Dr. Frothingham. No; you have perfect freedom, the way you have it now.

Suppose I am a great surgeon and you have got a bad gall bladder and you come to me and say, "I haven't any money. Will you take my gall bladder out"; and I will say, "No" or "Yes," perhaps. There is no compulsion anywhere along now. There is no compulsion under this plan. Yet that is just the point that I brought up and people are trying to make it evident we are all going to be regimented by the Government, employees of the Government, and have got to do as we are told. That is absolutely erroneous.

Mr. O'Hara. Of course, they cannot compel a doctor to go in under the plan and cannot compel the doctor to operate on his own patient if he does not have the money to pay for the operation. Is that not true?

Dr. Frothingham. Yes.

Mr. O'Hara. Doctor, is your warfare with the American Medical Association one that the association is not organized by not only doctors——

Dr. Frothingham. I did not get your question.

Mr. O'Hara. I say, I take it that your relationship with the American Medical Association, from the questions asked by Mr. Biemiller and your answers, is not friendly. Is that correct?

Dr. Frothingham. Oh, I am a member in good standing and every now and then I get quite a write-up in their editorial page, which is not always complimentary, but I rather enjoy it.

My real criticism of the American Medical Association is that it does not allow freedom of the medical press. I think here we have got a very controversial subject as to the best way to deliver medical care to the American people and the medical press will not allow a fair and open discussion of the subject.

Mr. O'Hara. Do they publish any of your editorials?

Dr. Frothingham. I do not write editorials.

I happen to belong to another committee, known as the Committee of Physicians, for improving medical care, that really studies legislation very carefully and makes a careful survey of what the legislation proposes and then criticizes it, and over the years the Journal of the American Medical Association has refused to publish those things.

Mr. O'Hara. They have?

Dr. Frothingham. Yes. I am glad to say we are a little more broad-minded in Massachusetts, because the New England Journal of Medicine, which is the official organ of our State society, will publish both sides of the question.

Mr. O'Hara. That is your State society?

Dr. Frothingham. Yes.

Mr. O'Hara. Now, of course, there are various sections within the American Medical Society. There is a group known as the physicians and surgeons and those who are particularly qualified as surgeon in the surgical branch of the American Medical Society?

Dr. Frothingham. There are various sections. There is a section of medicine, a section of surgery, a section of ophthalmology, and so on down the line.

Mr. O'Hara. Well, the division is a recognition of that particular doctor's skill based upon the findings of a committee of doctors themselves, who pass upon that man's work; is that not true? That is, that doctor's work?

Dr. Frothingham. I do not think that is quite accurate.

There is an attempt on the part of the American Medical Association, along with other groups of organized medicine, like the physicians and surgeons; American College of Physicians; American Association of Ophthalmologists, and so forth, to try to define specialism. I believe I am right in saying that there is no one branch of the American Medical Association that defines specialism. I may say specialism is defined by a combination of these various groups and they do get out a directory of American specialists, but that has no legal standing.

Mr. Priest. Are there any further questions?

Mr. Wilson. Mr. Chairman.

Mr. Priest. Mr. Wilson.

Mr. Wilson. Doctor, you say that the group you belong to makes an analysis of proposed legislation?

Dr. Frothingham. Yes.

Mr. Wilson. Other than the comments you have made in your testimony before the committee, do you have a published analysis of this proposed legislation?

Dr. Frothingham. We have a published analysis. This is not the Committee for the Nation's Health I am speaking for. This is another committee.

Mr. Wilson. I understand.

Dr. Frothingham. And we have a statement in regard to the bill put in by Senator Wagner and others before the last Congress, and I understand that Senate bill 5, put into this Congress, is practically the same, and the analysis of this actual recent bill, the number——

Mr. Wilson. H. R. 4312 and 4313——

Dr. Frothingham. That statement is being whipped in shape at the present time. So, our anlysis of the bill that is being whipped in shape at the preesnt time, on the existing bills, will probably be very similar to the analysis of the bill that was introduced in the last Congress, and those can be very readily obtained by writing to John P. Peters, at New Haven, Conn. He is professor of medicine, Yale Medical School, and he is secretary of that group and has all of the publications, and he will be very glad to send them, I am sure.

Mr. Wilson. That analysis will published soon?

Dr. Frothingham. We are having a meeting in June to get out the report on this present bill which I think will be a very similar report to the one on the bill in the last Congress.

Mr. Priest. Any further questions?

Mr. Scott. Yes, Mr. Chairman.

Mr. Priest. Mr. Scott.

Mr. Scott. Do you contemplate that under this plan it would be possible for the doctors to be confronted in this country as they are in England, with the ability to charge only about $3.40 per patient per year, although they may take up to 4,000 patients? Could that happen under this bill?

Dr. Frothingham. I cannot conceive of it happening unless it is going to be for the benefit of the patients.

Mr. Scott. Could it happen under the bill?

Dr. Frothingham. I do not think so. The details in regard to all this method of thé program have not been worked out to the present time; but I cannot conceive of getting into any trouble in the paying of doctors.

Mr. Scott. Well, Doctor, I have a letter from a doctor in Germany, to whom I may say I send medical books and gifts for the family from time to time, and I understand from him that they have been trying socialized medicine since 1888, and he tells me that he is required to treat one patient as often as the patient may require at the rate of 1 mark and 20 pfennigs, which I think is about 50 cents per month, under the German plan, which is administered under the American and French occupation authorities. Could that happen under this bill?

Dr. Frothingham. Nobody is required to do anything under this bill.

Mr. Scott. Suppose they join the compulsory prepaid medical plan?

Dr. Frothingham. Yes.

Mr. Scott. Then could that happen under this bill?

Dr. Frothingham. I should not think so.

Mr. Scott. What I am getting at is, nobody under this bill is required to enter a squirrel cage, but when he enters that cage, could he then find himself confronted with the same situation which prevails in England and Germany with regard to the amount which they may be paid?

Dr. Frothingham. No, because the door is open and they can get out.

Mr. Scott. They can walk out?

Dr. Frothingham. Yes.

Mr. Scott. Having in the meanwhile given up their private practice?

Dr. Frothingham. People are going in and out of private schools, and in and out of public schools into private schools in this country as they choose.

Mr. Scott. And having gone from private practice to public practice, or vice versa, I assume that they can do that with equal facility under this bill?

Dr. Frothingham. Well, I do not admit that this bill can be called a public plan. I do not think that this bill can be called a public program. There is no change in the personal relationship between the patient and the doctor under this program except that there is not a dollar bill passing between the patient and the doctor. The doctor does not have to worry about getting his money. The patient does not have to worry about paying.

Mr. Scott. Who does worry, Doctor?

Dr. Frothingham. Well, apparently you are.

Mr. Scott. I am worried. I assure you that I am quite a bit worried. I am elected to represent 304,000 taxpayers, and I am asking who does worry besides me.

Dr. Frothingham. I think there is not any worry, because the money is collected on a broad basis and you are not putting a financial strain on any individual. It is collected in proportion to the person's ability to pay, and the financial barrier which is one of the worst worries in my practice, whether you or somebody else is the patient, lots of times, will cease to exist.

Mr. Priest. Any further questions?

Mr. Bennett. Yes, I have one or two other questions.

Those of us who live in rural communities, Doctor, know that, for example, in operations—I guess major operations, such as removing the appendix or those of similar nature, to a large extent are performed by the family doctor; by the doctor in general practice. In other words, the general practitioner in the community.

Dr. Frothinhgam. Yes.

Mr. Bennett. And not by a so-called specialist.

Now, what is going to happen under this bill if people who are eligible, having their own choice of physicians, elect to go to a surgeon who is designated under this law as a specialist in that kind of a procedure?

Dr. Frothingham. I think I see your point. It is a very important one. It is one we have to spend a lot of time in trying to figure on, because, in the first place, there would not be enough real, high-class specialists to go around.

There is no doubt but what the general practitioner, in many communities, can do a certain amount of general surgery and do it perfectly satisfactorily, and there is being given thought and there will have to be given a lot more thought, to see that the general practitioner who gets paid for his work as a general practitioner will also be able to receive something extra where he does extra work, and that will have to be worked out, because there are just not enough fellows really classified as good surgeons to do all of the surgery that is needed.

Mr. Bennett. I wonder what effect the bill is going to have on balancing out service. In other words, in a community you may find under certain circumstances such as I described a few minutes ago, you may find everybody in the community wants to go to this one doctor because he is a specialist, and change entirely their system of using their own physician simply because under a law that we pass, they have the right to a specialist's care.

How are you going to meet that.

Dr. Frothingham. In the first place, specialists do not have to take them. There is nothing in the law that makes the specialist take them, whether they participate in the scheme or not. If I participate in the scheme, I do not have to take any individual subscriber.

Mr. Bennett. Well, I am assuming he is glad to do so and will take them, at least to the extent of his ability.

Dr. Frothingham. There is another very fortunate and strong provision in this proposed legislation and that is that the patient must work through the family physician.

Anybody who has been practicing as long as I have, sees a tremendous amount of bad and unnecessary surgery done by the layman trying to short-cut to the surgeon of his choice and his judgment is bad, and in any good medical program, the individual patient should be guided by the family physician, who knows him individually, and that is what this calls for.

Mr. Bennett. Should be guided, but will he?

Dr. Frothingham. You have to be, if you are going to get the money from the Treasury.

Mr. Bennett. How far will a person be permitted to go in seeking the physician of his own choice? Under this bill, will he be confined to his own community or will he be able to go to some doctor 100 miles distant, if he prefers that doctor, and that doctor is willing to take him as a patient?

Dr. FROTHINGHAM. Well, I cannot conceive of that doctor taking on a patient 100 miles away, if it happens to be in the snowy country, because the patient would only have to call him up on two successive nights after a blizzard and pretty soon the doctor would give up that patient.

Mr. BENNETT. I know, but that snow condition does not prevail in large sections of the country.

Dr. FROTHINGHAM. It might be muddy.

Mr. BENNETT. Well, what I am trying to get at is, I am trying to figure out what effect that is going to have on the balancing of practice in these various places.

Dr. FROTHINGHAM. I do not think it is going to change matters at all.

As I have said repeatedly here this morning, the only difference is you are not going to have the difference between the patient and the doctor in regard to dollars.

Mr. BENNETT. Well, when you get a case in a rural community—I will get back to appendectomies. People have their appendixes removed by family physicians, and it is perfectly satisfactory. But would you deny them the right to go to a man who does nothing but take out appendixes, and are you not setting up a system whereby you are going to throw a large part of that work out of the hands of the regular doctors into the hands of so-called specialists and disrupt your whole system?

Dr. FROTHINGHAM. I really do not think so, because, in the first place, there is a limit to the amount of time a fellow can put in, and, therefore, if the specialist gets overcrowded, he cannot accept the patients.

Mr. BENNETT. That is one of the unknowns of this program.

Dr. FROTHINGHAM. I think that is just about the way it is now.

Mr. BENNETT. That is all.

Mr. O'HARA. Let me ask you this question. I live in a community where there are six doctors, we will say, and two are fine all-around doctors, they use surgery in practically every form and give X-ray treatments. In other words, they carry on what a good country doctor carries on as a general practice, they not only do surgery but internal medicine and everything else.

Now under this bill one of those two doctors goes in under this program. What happens; does he give up all his regular patients? Suppose we have this situation, as I understand exists in England. The thing the doctors claim, as I read the articles which are written on it, is that they are overworked, they are taking care of as many as 3,000 and even 4,000 patients on an average a year. We will keep it in this field of six doctors, two of which are outstanding. The one becomes loaded up with a tremendous amount of work. Is he permitted to take on patients who are not in the program?

Dr. FROTHINGHAM. It depends on what kind of contract he makes. He can go into the program on the basis of putting his mornings into this program and putting his afternoons into something else. There is no limitation, no difference from what it is now.

Mr. O'HARA. But how can he possibly do that?

Dr. FROTHINGHAM. How many patients can he see in a day? Let us assume he can see 10 patients in a day.

Mr. O'HARA. If he is in general practice he is up in the hospital all morning, is he not?

Dr. FROTHINGHAM. Yes.

Mr. O'HARA. He is operating on these patients and what portion is going to be in this program and what portion in the private practice?

Dr. FROTHINGHAM. That depends on how many in the program want to use him as a private physician or want to use him to be paid for out of the funds.

Mr. O'HARA. If he goes into the program, and let us say he is the only one of the six that goes into the program, and these people pour in there, what is he going to do?

Dr. FROTHINGHAM. He does not have to take them.

Mr. O'HARA. Does he not have to take all of them?

Dr. FROTHINGHAM. He cannot take more than he can treat properly.

Mr. O'HARA. The doctor is still up against that problem, is he not, and this bill is not going to change the relationship between the human and the physician, is that right?

Dr. FROTHINGHAM. That is right.

Mr. O'HARA. The doctor can only do so much?

Dr. FROTHINGHAM. That is right.

Mr. O'HARA. That is going to exist whether they have to pay for it out of their pocket or whether Uncle Sam pays for it?

Dr. FROTHINGHAM. I do not quite get your point.

Mr. O'HARA. The doctor is still going to be able to do only so much work?

Dr. FROTHINGHAM. That is right.

Mr. BIEMILLER. Will the gentleman yield?

Mr. O'HARA. Yes.

Mr. BIEMILLER. I would like to point out that that situation exists at the moment where there are any Blue Shield programs or any similar programs. The doctors are practicing in part under the insurance plan and in part under strictly private practice.

Mr. O'HARA. The point I am making is that whether Uncle Sam pays for it, the patient pays for it, the question is still whether the doctor can do the job, is it not?

Dr. FROTHINGHAM. I should think so.

Mr. PRIEST. Have you any further questions, Mr. O'Hara?

Mr. O'HARA. No.

Mr. PRIEST. If there are no further questions, I have just one question, Doctor. While most of your statement and most of the questions, if not all, have related to title VII of this bill, as I understand it in your preliminary statement, you said you approved other titles in the bill also?

Dr. FROTHINGHAM. Yes, sir.

Mr. PRIEST. We appreciate your appearance and thank you so much for the time and patience you have given us.

Dr. FROTHINGHAM. I enjoyed it.

Mr. PRIEST. Our next witness will be J. Donald Kingsley, Assistant Administrator, Federal Security Agency.

STATEMENT OF J. DONALD KINGSLEY, ASSISTANT ADMINISTRATOR, FEDERAL SECURITY AGENCY, WASHINGTON, D. C.

Mr. PRIEST. Mr. Kingsley's prepared statement was entered into the record on the opening day of the hearings, gentlemen.

I might say that it will be necessary for the committee to adjourn at about 11:45.

Mr. Kingsley, if you care to summarize your statement, already in the record, and then answer questions, that will be entirely agreeable, I am sure, with the committee.

Before we start the Chair would like to recognize the gentleman from New Jersey, Mr. Wolverton, the ranking member of the minority on the full committee. I would also like to recognize Mr. Heselton, of Massachusetts, also a member of the full committee.

Mr. KINGSLEY. Mr. Chairman, and members of the subcommittee, I am very happy to appear here in respect to H. R. 4312 and H. R. 4313, which have been introduced, as I understand it, pursuant to recommendations of the President and in accordance with the program of the administration.

As the chairman has indicated, my full statement has been included in the record and I shall try to summarize it as briefly as I can at this time. I would like, however, to call the attention of the committee to one paragraph from the special message of the President of April 22, 1949, in which he said:

> Our objective must be twofold: to make available enough medical services to go around, and to see that everybody has a chance to obtain those services. We cannot attain one part of that objective unless we attain the other as well.

It seems to me that that particular statement is of considerable importance as underscoring the philosophy underlying the administration recommendations. As a matter of fact, if we are to improve the health of the American people, we are confronted with three related problems. First of all, there is a problem of shortages of personnel and facilities, current shortages, and almost all parties in interest are agreed that such shortages exist; that we have shortages of physicians, hospitals, nurses, and other types of trained personnel.

Secondly, we have the problem of the distribution of those facilities which we do have with a high concentration in certain areas of the country and with a consequent undersupply in certain other sections of the country.

Thirdly, we have a problem underlying all of these, the problem of an inadequate supply of purchasing power, the inability of a large sector of the American people to purchase adequate medical care under a system in which the whole cost of that care falls upon the sick.

Now, Mr. Chairman, before dealing more specifically with these three problems, perhaps it would be well to ask what all of the shooting is about? Are we not the healthiest nation in the world? We often hear the statement made that we are and perhaps we are, although it depends upon which particular indices of health and well-being one examines as to whether we rank first or as to whether other countries rank first. The important point, however, is that we are not as healthy as we can be or as we should be with the modern facilities at our disposal or the modern knowledge at our disposal; there is vast room for improvement.

I am not going to go into any detail in citing statistics on this point. I think all of us were shocked by the selective-service statistics and by the fact that one-third of our young men proved to be incapable of serving their country in a time of need because of physical or mental defects.

I am perfectly aware that there has been a good deal of controversy as to the meaning of those statistics but I am also perfectly certain that no matter how much you discount them, you are still left with figures which indicate vast room for improvement, figures that indicate defects which could have been corrected by medical science and which should have been corrected.

In this connection, Mr. Chairman, I should like to call your attention to the study made in North Carolina which showed that the rejection rate—so far as the selective service was concerned—the rejection rate among children brought up in orphan asylums where they had medical care at all times, was much lower than the rejection rate of children of better-favored families, or so-called better-favored families.

It seems to me to be a very significant study bearing on this point.

Moreover, the health statistics show that there is wide variation in the health of people from one part of the country to another, from State to State, and from one community to another and from one area to another. In New York 1 mother dies per 1,000 live births and in Mississippi the rate is three times as high.

So, the fact is that while our medicine has made striking gains, those gains have been ragged and uneven. The reason for this is economic and not medical.

The three basic problems which I have already outlined and which stand in the way of further progress all rest on an economic and not a medical base. There is the shortage of manpower and facilities, an inequitable distribution of manpower and facilities, and the inadequacy of medical purchasing power. We do not have enough doctors, dentists, nurses, hospitals, and clinics, in large part at least, because we have no way to support them if we had them under the present system of paying for medical care. I will use only the hospitals as an illustration. Even with the expenditure of substantial amounts of Federal funds for the construction of hospitals, there are large sections of the country where we cannot build hospitals because even if they existed the people could not sustain them; they could not be supported and we do not build hospitals by and large and certainly we should not build hospitals because it makes no sense to build them in areas where they cannot be maintained.

Similarly, in terms of the inequitable distribution of the facilities and manpower, by and large the distribution of medical manpower and medical facilities, follows the general pattern of income distribution in the country so that in New York State, for example, with an average per capita income of somewhere around $1,600, we have five hospital beds per 1,000 population and we have 1 doctor per 500 of population; whereas in Mississippi with a per capita income of about $600, we have less than 2 hospital beds per 1,000 and about 1 doctor per 1,500. Similar discrepancies exist all the way across the country both as between sections, as between States, and as between communities within States.

In general, the rural areas are underprivileged in respect to the urban areas and the South and West are underprivileged with respect to the Northeast in terms of the distribution of these facilities.

Perhaps the most striking example that we have is in the distribution of baby doctors, pediatricians, only 4 percent of whom are now located in those areas of the country where 60 percent of our children live. The pediatricians are in the area where the income is and the children are in other parts of the country. Similarly, there is a wide discrepancy in the distribution of our public health facilities, and so on.

Now clearly these differences in the availability of facilities and of personnel are not related to differences in health problems. There are not fewer health problems in the South and West than there are in the Northeast. They are not related to that; they are related to income, and the problem is an economic problem.

Thirdly, the lack of purchasing power in general is also obviously an economic problem. Even if you live in New York which has the highest ratio of hospital beds and of physicians, and so on, to population, even if you live there, the chances are that you do not get the kind of medical care that you ought to receive and that you need because of the high costs of paying for such care under this archaic system in which the total cost falls upon the sick and under a system in which it is completely impossible for the individual, no matter how prudent, to predict or set aside a sufficient amount so that he is certain that he will not be thrown into bankruptcy at any moment as a result of an unpredictable and severe illness.

I have cited in my statement one illustration which has recently been mentioned in the papers of a middle-class family in Louisville, Ky., where the mother in the family had an illness requiring $60 a day for medicine, a family which had always been a self-supporting family, which was necessarily thrown into bankruptcy and upon charity because of this medical expense.

In general, we would estimate that at least half of our population cannot afford adequate medical care, including preventive care at the present time.

Now for these and other reasons it seemed to us and to the authors of the bills before this committee, that a comprehensive multilateral attack was required. All of these are related problems, they are related to an economic problem. The program before you and the bills put in by Representatives Dingell and Biemiller make a multilateral approach to these problems. They approach directly the problem of expending medical personnel. They approach directly the problem of expanding the number of hospitals and of clinics, and so on.

They approach directly, in title IV, the problem of the undernourished area from the medical standpoint, the rural and other shortage areas. They approach directly the provision of local health units and they cap the whole system by providing in title VII a means by which the people can pay for these services once they have them. There is no advantage in the long run in substantial increases in facilities unless we at the same time provide some means by which the people can use them.

Critics have claimed that this is a plan of socialized medicine. I would say that that is complete nonsense; that this program has no connection whatever with socialized medicine. The administration does not want socialized medicine and it is in fact offering health insurance as the one hopeful way of avoiding it. We have all seen, particularly in recent years, the trend toward socialized medicine. There has been a very marked trend until today, according to the Hoover Commission, 24,000,000 American citizens are the beneficiaries of socialized medicine under different programs adopted by the representatives of the American people. That number has been growing rapidly and it is inevitable that it will continue to grow in response to the need that this represents unless we find some other means of enabling the American people to secure and pay for the type of modern medical care that they need.

As I see it there are only three alternatives. We can continue as we have been doing in the past to extend socialized medicine. We can at the other extreme adopt a charity program under which the Government attempts to underwrite for all of those people in the United States the costs of medical care which they cannot bear themselves.

In our view this would result in pauperizing a very substantial portion of the American people. Or, thirdly, there is the middle way which is through health insurance, providing through an insurance system a method of spreading the cost, of permitting normally self-supporting families—the great bulk of working and middle-class families in the country—to support themselves and not to have to rely upon charity in any respect. By making it social insurance, which means that the costs are related to ability to pay, that becomes possible. This is the middle way, it is the American way, the tested way in terms of our other social-security programs. Its adoption would have little or nothing to do with the various alarms which are being raised in respect to what this program means.

Doctors would, as you know, remain in private practice, hospitals would remain under private ownership and control. No doctor would have to join and no hospital would have to join. The Government would neither own nor control the practice of medicine. All it would do would be to help to erect an economic foundation under the private practice of medicine in this country, an economic foundation which any who examines the statistics on the subject will see is today completely lacking.

I think, Mr. Chairman, that while I have really touched only the very highest spots, that in general summarizes my formal statement.

Mr. Sadowski. Thank you.

Mr. O'Hara?

Mr. O'Hara. Mr. Kingsley, I suppose you know as much about H. R. 4312 and H. R. 4313 as anybody; is that true?

Mr. Kingsley. I doubt that, I am sure there are people who know more than I do about it, but I have read the bills two or three times.

Mr. O'Hara. Are you not, as a matter of fact, one of the draftsmen of these bills?

Mr. Kingsley. No, sir; I am not.

Mr. O'Hara. Are you one of the draftsmen?

Mr. Kingsley. I have had nothing to do with the drafting of these bills. I understand that the original bill some Congresses ago was drafted by the Federal Security Agency, or drafted at the request of the sponsors. In this particular instance the agency did provide on the Senate side a technical draftsman to assist in the drafting but this is not our bill and in fact in our report on this bill you will notice that we have made a number of suggestions for changes.

In general, it carries out the recommendations of the President and of the administration, but it has not been written directly by the administration; it has been written by the sponsors.

Mr. O'Hara. Mr. Kingsley, how many different forms of medical care are being provided by the Federal Government today? I am thinking of the Veterans' Bureau, the Veterans' Administration, Public Health, and so forth?

Mr. Kingsley. Well, let me think a moment.

Mr. O'Hara. In other words, where the patient is furnished complete medical care or at least partial medical care?

Mr. Kingsley. Under the veterans' program, as you know, Congressman, complete care is provided for all veterans with service-connected disability and for all needy veterans; that is, any veteran who takes a means test and signs an affidavit that he cannot pay for it is eligible.

Secondly, under the Public Health Service Act, establishing the marine hospitals, all merchant seamen are entitled to Government care. Then, including not only what the Federal Government does but the States and localities, for the most part tuberculosis and mental and chronic-disease patients are taken care of at Government expense.

Finally, we have the people on relief, the indigents who in turn are supported, whose medical care is taken care of for the most part by State and local governments but with matching funds from the Federal Government.

I think the Hoover Commission estimated that the direct Federal is about $24,000,000.

Mr. O'Hara. How many people do you think would be served under the proposed bill?

Mr. Kingsley. Somewhere between 120,000,000 and 125,000,000, as I read this bill.

Mr. O'Hara. Would we discontinue the present programs? Does that contemplate the discontinuance of the present programs that you just outlined in existence today?

Mr. Kingsley. I am not certain that that is contemplated. I would answer it this way, Congressman: Certainly there would be no incentive for the creation of additional programs or for their extension and the tendency in time would be, I should think, to get rid of some of the special programs.

Mr. O'Hara. You say that this is not a socialized medicine program; that this is a health insurance program, is that correct?

Mr. Kingsley. Yes, sir.

Mr. O'Hara. What is the distinction which you make between socialized medicine and this proposal so far as the health program is concerned?

Mr. Kingsley. I should define a program of socialized medicine as one under which the Government owned and operated the facilities, medical and health facilities, of the country, and in which the medical personnel was on the Government pay roll, bureaucrats like other people on the Government pay roll. That is not proposed here.

Mr. O'Hara. If we have this program, the doctor on the program is on the pay roll of the Federal Government?

Mr. KINGSLEY. Not at all, Congressman, no more than he is on the pay roll of the Blue Shield if he gets paid by Blue Shield.

Mr. O'HARA. He is paid by the Government, is he not?

Mr. KINGSLEY. Oh, no. The insurance fund reimburses him; it is a Federal insurance fund similar to State compensation funds, but he does not work for my State of Ohio just because he gets a check from the State compensation fund for treating a fellow.

Mr. O'HARA. That fund is paid in by the taxpayers of the United States or by the people who contribute to the fund under this plan, is that not right?

Mr. KINGSLEY. That is correct.

Mr. O'HARA. The patient's bill is paid for in that manner, is that not true?

Mr. KINGSLEY. Yes; that is true.

Mr. O'HARA. Do you think the Federal Government would not exercise any control, any regulation, as to fees or as to conduct of the doctor and the patient with reference to this program?

Mr. KINGSLEY. That seems to me to be very completely spelled out in these bills, Congressman, as to precisely the areas in which the Federal Government can exercise any control. By and large the emphasis in these bills is upon completely decentralized administration, upon complete local control, and I think so far as the actual operations are concerned—the administration—that practically anything directly affecting the provision of medical care is taken care of by local committees composed of local citizens and doctors and with the advice and approval of the advisory committee at the local level.

The administration is shoved down to the very lowest point.

Mr. O'HARA. Who collects the money?

Mr. KINGSLEY. The money would be collected by the Bureau of Internal Revenue on the same basis as they collect taxes now.

Mr. O'HARA. Who would pay it out?

Mr. KINGSLEY. It would be disbursed by the Treasury upon certification by the National Health Insurance Board as to the allotment that would go to each State and then the State plans would in turn determine how it was paid out in the State.

Mr. O'HARA. How much would be paid to the State of Minnesota?

Mr. KINGSLEY. Its proportional amount in terms of its population, and so on. I just do not know, but of the total amount collected it would get its proportional amount.

Mr. O'HARA. Do you know of any administration of the Federal Government in which the Federal Government is the collector in which it does not exercise some control over the funds, whether written in or otherwise?

Mr. KINGSLEY. I think the tail end of your question makes it a rather double-barreled question.

Mr. O'HARA. Eliminate the last.

Mr. KINGSLEY. On the first part of the question, I would say that offhand I do not, because I think that quite correctly the Congress does lay down rules and regulations as to what the money is to be used for. But, so far as those are specifically laid down and agreed to by the representatives of the people, I see no objection to that.

Mr. O'HARA. Let me ask this question: In my congressional district there are 14 counties. Let us say that there are 7 of them who do not go into the program in any way, shape or form, the doctors just do not go in.

Mr. KINGSLEY. Yes.

Mr. O'HARA. What happens to the indigent person who needs medical aid and has to travel, say, 100 miles to get it?

Mr. KINGSLEY. Of course under this program, Mr. O'Hara, the indigent person is treated anyway. The indigent does not pay any tax, you know.

Mr. O'HARA. Let us say the man who is an employee, who goes into the program, and has to have medical care. What happens to him?

Mr. KINGSLEY. Accepting your assumption, which seems to me to be almost impossible and completely unlikely——

Mr. O'HARA. I think it could very well happen in my district.

Mr. KINGSLEY. Accepting that, the man's only resource would be everything he has now. He can deal in the same way with the local doctors. In other words, he loses nothing.

Mr. O'HARA. But he is paying in and he wants to participate?

Mr. KINGSLEY. That is right. Under the program there is provision that the States would set up local health districts. Now I cannot imagine that the State of Minnesota would set up a local health district that had no participating doctors in it.

Mr. O'HARA. I do not think we can say anything is unlikely.

Mr. KINGSLEY. I might point out that in title IV there are provisions for settling additional districts.

Mr. O'HARA. Who does that?

Mr. KINGSLEY. Under title IV, by the National Health Insurance Board.

Mr. O'HARA. From Washington?

Mr. KINGSLEY. That is right, up to an expenditure of $35,000,000 for such purposes.

Mr. O'HARA. Who sets up the Board under this bill?

Mr. KINGSLEY. The Board is provided for and spelled out in some detail under title VII, part F, section 751.

Mr. O'HARA. Just generally?

Mr. BIEMILLER. Will the gentleman yield?

Mr. O'HARA. Yes.

Mr. BIEMILLER. The Board is a five-man board consisting of the Federal Security Administrator, the Surgeon General of the Public Health Service, and three others to be confirmed by the Senate, at least one of whom must be a physician.

Mr. KINGSLEY. Appointed by the President.

Mr. O'HARA. Taking this hypothetical situation which you say is highly unlikely, suppose we did have seven counties in which the medical profession did not enter into the program and Washington sends out a doctor into that community who takes care of those participating in the program, you still say, Mr. Kingsley, that this does not amount to socialized medicine?

Mr. KINGSLEY. Washington would not send out a doctor. Washington would provide incentives under title IV of this bill for doctors to settle in that area in terms of paying transportation costs for their families if they wanted to go, in terms of making loans for getting clinics set up and getting equipment and in terms of a grant, if necessary, to cover losses in terms of operations when they get there. But the doctor is not on the Federal pay roll.

Mr. O'Hara. I understand. That is all.

Mr. Priest. Mr. Sadowski?

Mr. Sadowski. References have been made here to blue-sky medicine, socialized medicine, in a sort of derogatory way and it seems to me that there is nothing derogatory about socialized medicine. The fact is that we have had it in the city of Detroit, my home city. We have had socialized medicine for many, many years and we have practiced it under both Republican and Democratic administrations. The truth of it is that we have what we call the city public-health system there whereby doctors are hired on an all-year-round basis by the city of Detroit and paid from funds that are collected from the city taxpayers.

Medicine is being administered free of charge to the indigent, to the people who are on public welfare. Our public-health bureau is geared up to handle about 350 cases a week. I just read in the Detroit papers a couple of weeks ago where our load is now 700 a week at the public-health bureau, and the doctors are just rushed to death and they are asking for additional help.

Now the additional load has been thrown on because of the conditions of unemployment and the bad economic conditions which are already exhibiting themselves in my city.

Now, there is nothing wrong about that, I mean nobody in the city of Detroit thinks anything wrong about the public-health bureau. As a matter of fact, the public-health bureau has been largely responsible for stopping many contagious diseases and plagues that would have affected the public health of the people of the city of Detroit such as diphtheria and things of that sort. They have attacked it quickly and done a marvelous job on it.

So, these references to socialized medicine are not going to frighten a lot of clear-thinking people at all because it has already been adopted.

I think there is a vast difference between this bill and the public health system as it is being administered in the city of Detroit, a great deal of difference, because you are not running a big bureau here with a lot of doctors that are on a salary basis and responsible to the city authorities; it is not welfare work, everybody would be contributing to national health insurance and eevrybody would benefit from it.

I make these remarks because those references to "blue sky" get under my skin as do the references to socialized medicine.

Mr. Scott. That happens.

Mr. Priest. Mr. Biemiller?

Mr. Biemiller. No questions.

Mr. Priest. Mr. Scott?

Mr. Scott. Mr. Kingsley, you have made the statement that we do have socialized medicine in this country, public-health service, Veterans' Administration, and so on, and that therefore the extension of what you call national health insurance is desirable, is that right?

Mr. Kingsley. That is not correct. The first statement is not the basis upon which I would say the extension of health insurance was desirable, Mr. Scott. I think that one of the objectives, as I take it from the outcry, one of the objectives is to avoid socialized medicine and that this is the most logical way of doing it. But, I would put the case for health insurance on a much broader base than that in terms of taking an action, appropriate action, to improve the health of the American people and that this is the most practical means of doing so.

Mr. SCOTT. Of course, I may point out that we Congressmen are elected to listen to the outcries, as you put it. Would not your same argument for the extension of compulsory distribution of medical services equally apply to other things, the cost of which is too great to pay?

You quoted Mr. Lincoln as saying, "What the individual cannot do for himself, or do as well, the Government should do." If you apply that reasoning, and I doubt very much that Mr. Lincoln meant that government should do everything, but if you were to apply that reasoning, would not your reasoning likewise apply to the legal profession because the cost of legal services is frequently much greater than the people can pay? Would you, therefore, advocate the extension of a compulsory program against the cost of legal services?

Mr. KINGSLEY. No, because there is a considerable difference in degrees of urgency as between medicine and legal services, one is a matter of life and death and the other is not.

Mr. SCOTT. Let us take your word "urgency."

Mr. KINGSLEY. I might say that where it is a matter of life and death the State already provides counsel.

If I am accused of murder, I can have counsel provided and that has been true as far as I know since back as far as Elizabethan times.

Mr. SCOTT. Not by the Nation, but by the local communities or States.

Mr. KINGSLEY. By the local governments.

Mr. SCOTT. I will pick up the word "urgency" and go from there. We have had high authority in this country for saying that the cost of food is much too high even for people who can afford to pay. In the Veterans' Administration and in the Army and Navy you have a compulsory administration of food. Will you also argue that the cost of food is high and people cannot afford to pay it and, therefore, there should be a compulsory distribution of food to people? Food being a matter of life and death under certain circumstances?

Mr. KINGSLEY. Congressman, I have supported for a long time the school-lunch program; yes, in that respect.

Mr. SCOTT. Would you expand, please?

Mr. KINGSLEY. Where the demonstrable relationship between the health of the people is there as in the case of the school-lunch program, I would be very much in favor.

Mr. SCOTT. Therefore, you would support the compulsory distribution of food in this country?

Mr. KINGSLEY. I did not say that.

Mr. SCOTT. You picked the school-lunch program up, how much further would you go?

Mr. KINGSLEY. Again I say it is a matter of degree.

Mr. SCOTT. We have also understood that people are ill-clothed. In some circumstances clothing in wintry countries may be a matter of life and death. The Government makes compulsory the distribution of clothing to Army and Navy and in other areas. Would you favor compulsory distribution of clothing to all Americans on the ground that the Government can do it better than the people can do it themselves?

Mr. KINGSLEY. No, sir; I would not. But, again, let me make clear the general principles that seem to lie here, and which relate to my use of the word urgent. So far as the Government is concerned, social insurance relates primarily to providing those conditions under which the individual can get security for himself. In other words, in terms of insuring against hazards which he cannot possibly deal with himself.

In connection with your question about clothing, it is perfectly possible and in fact happens every day that Government does intervene to provide clothing for our indigent people. During the depression it was on a much wider scale; at the present time it is on a much smaller scale. The Federal Government contributes money to the States for that purpose and has for years, at least since 1936. Where it becomes a matter of real urgency to the individual and he cannot deal with that situation himself, it is a matter of tradition in this country that the Government has done so.

Mr. SCOTT. You mentioned the geographic distribution of medical personnel. Would you propose to shunt doctors around or move them to places where there is not a better distribution?

Mr. KINGSLEY. No, sir; the theory of this bill is based entirely upon the classical theory of economics that supply will follow effective demand. The problem is that we do not have effective demand in the country and that is why we have medically undersupplied areas in the country.

Mr. SCOTT. Your statement says that during the past 10 or 15 years we have seen a very rapid growth of the so-called voluntary insurance plan. Why do you then propose to counter and bring to a halt this rapid growth?

Mr. KINGSLEY. In my judgment there is no possibility, and I say it as flatly as that, no possibility, that the basic problem with which we are here confronted can ever be met by voluntary insurance, for a number of reasons. Foremost among them is the fact that premiums under voluntary and commercial insurance are not related to ability to pay and the distinction between social insurance and every other kind of insurance is that social insurance is based upon ability to pay.

The 60,000,000 people living in families with incomes under $3,000 cannot by and large afford the premiums of voluntary and commercial insurance companies; that is, half of our population or very nearly half.

Mr. SCOTT. You say on page 16 that the cost to the employer and employee would be $39 a year on a man making $50 a week and on the self-employed person, $108 a year. My recollection is that the Blue Cross premium I pay is $27 a year. Are you not proposing something that is more, rather than less expensive?

Mr. KINGSLEY. I am a member of the Blue Cross also and I think I pay $48 a year but for that, what do I get? I do not get any medical care; all I get is hospitalization and somewhat limited hospitalization at that.

Mr. SCOTT. How much more than the $48 a year would you have to pay under the Blue Shield for the medical care?

Mr. KINGSLEY. Under the Blue Shield, I do not know what the premium would be.

Mr. SCOTT. The two together would still be less than the $108 which you contemplate the self-employed would be forced to pay?

Mr. Kingsley. I can provide that for the record but I am sure that it would be substantially less.

Mr. Scott. From my experience I have never known a Government service to cost less than a private service.

Mr. Kingsley. I could supply instances by the dozens in which the Government costs less than individual services.

Mr. Scott. I would be happy to have it.

The $108 a year, however, would that include free dentures, free eyeglasses, and free toupees for bald-headed men?

Mr. Kingsley. Yes, sir.

Mr. Scott. He would get quite a bargain from the Government, would he not?

Mr. Kingsley. This is much cheaper than private companies could provide it.

Mr. Scott. I say, the Government would give him quite a bargain for the $39 a year or $108 a year if he could get free toupees, eyeglasses, and the rest?

Mr. Kingsley. And complete medical care.

Mr. Scott. And his wife could get free girdles?

Mr. Kingsley. I would say that the wife would get free girdles if the physician thought she needed them.

Mr. Scott. My question is, Who makes up the difference because you said that the $108 or the $39 comes from the employer and employee or from the self-employed? If all these free services are to be given by the Government where does the Government get the money to give them?

Mr. Kingsley. Of course, they are free only in the sense you are defining it as given by the Government.

Mr. Scott. Where does it get it?

Mr. Kingsley. Incidentally, when you were referring to blue sky before, you must have been referring to the suggestions made to have the Government underwrite charity patients because there is nothing blue-sky about this; this is the only proposal that I know of in which the costs are precisely known because they are spelled out here in precise detail.

Mr. Scott. I was referring to blue sky in the sense in which States set up bureaus to protect their citizens from phony schemes. The Congress is here for the same purpose, if it shall be necessary.

Mr. Kingsley. I did not recognize the description as applied to this particular program; that is the only point I am making with regard to that.

Mr. Scott. The cost, I understand you have given us no figures on it at all, although you do mention that the cost of medical care in this country is $7,000,000,000 and it would be more than that. The cost in England is 8.5 percent of the national income, I believe, and 8.5 percent of the American income would be $17,000,000,000 a year. What assurance do we have that this program would not cost $17,000,000,000?

Mr. Kingsley. Well, the major assurance, the easiest explanation of that would be, Congressman, to take the total number of doctors in this country and divide any figure that they have in the way of income and see what it will come out to. With 145,000 practicing physicians at the present time, with 40 percent of all medical expenditures going to physicians, it would not take $17,000,000,000. I do not know what income you could come out with, but obviously it is an unreasonable amount of income for a physician to get so it could not come out to that.

Mr. Scott. Thank you.

Mr. Priest. Mr. Biemiller?

Mr. Biemiller. Do you want to continue now?

Mr. Priest. We will have to adjourn very shortly and we will reconvene at 2 o'clock. At that time we will have the president of the American Medical Association, who is scheduled definitely for that time.

Mr. Biemiller. Let me make one or two points before we recess, if that is the schedule.

Mr. Priest. Certainly.

Mr. Biemiller. Do I understand correctly that the National Health Assembly, Mr. Kingsley, unanimously agreed that there were grave deficiencies and difficulties in the preesnt distribution of medical care and recommended a contributory insurance system as the best means of answering it?

Mr. Kingsley. That is correct, including the representatives of the American Medical Association who participated.

Mr. Biemiller. I think that point ought to be established because in some of the questioning which has gone on here today, there is an implication that we can just stay in a stationary position and not make any move. I think by now everybody who is interested in this question is agreed that you cannot stand still; something has to happen.

Mr. Kingsley. I would say that is true.

Mr. Biemiller. So that actually the real controversy and I mean the controversy in terms of the Nation-wide discussion of this matter today, really centers on the question of voluntary versus compulsory insurance plans; that is what we have gotten down to after a number of years of discussion during which the American Medical Association has abandoned their position of opposition to voluntary plans.

You testified a few moments ago in answer to one of Representative Scott's questions that you felt that the cost of the voluntary plans was too high for the people below $3,000—I think that is the way you put it, below the $3,000-a-year income level. You also said that you had some other point that you wanted to make against the voluntary plans. I wonder if you would like to continue on that theme for a moment?

Mr. Kingsley. I suppose the cost factor is the most important and because of that the distribution of subscribers to voluntary plans tends to follow the distribution of income again. The voluntary plans so far are not correcting the inequities in terms of medical purchasing power as between different sections of the country. Something like 60 percent of all subscribers to voluntary plans are in six high-income industrial States. Only a very small proportion—I have forgotten what it is—3 or 4 percent, are in the rural areas and only about 17 percent are in the South and West, in the areas where we have the worst situation existing.

So that largely, as a result of these cost factors, the voluntary plans are not meeting the problems and there is no indication that they are ever likely to meet them.

Secondly, I mentioned the fact that premiums are based not upon ability to pay, but upon the service rendered, which again excludes a large part of the population who are not able to buy the types of service allowed in terms of income groups in which they find themselves. So that while the voluntary plans—and I am not against them in any respect, I am a member, as I have indicated, of Blue Cross—while the voluntary plans do have the advantage of spreading the risk among those able to pay and, therefore, making it more predictable for me as to whether I can meet a hospital bill, for example, they are not striking at the real root of the problem, which is to get medical purchasing power into the hands of the one-half or one-third, whatever you want to set it at, of the population that cannot afford now to buy medical care.

Mr. Sadowski. Is that all, Mr. Biemiller?

Mr. Biemiller. Yes.

Mr. Sadowski. Mr. Bennett?

Mr. Bennett. Mr. Kingsley, how many doctors are there in the United States today?

Mr. Kingsley. There are 145,000 practicing physicians and I believe there are about 30,000 more who are in public-health work or teaching and so on.

Mr. Bennett. How many doctors are we short for our needs?

Mr. Kingsley. Well, we are substantially short. Exactly what that shortage is is a matter of judgment. If we take the 12 States in which we have the most favorable ratio of doctors to population now and assume that that is a good yardstick because they are making a living and functioning and people are using them, the figure I have here is that by 1960 we would need to have 254,000 to meet that 12-State ratio. What it is at the moment, I do not know, but I guess it would be about 40,000 that we are short. I would not, however, conclude from that that you cannot handle health insurance at the present time because of a number of considerations.

In the first place even our most unfavored State in terms of number of physicians to population has a higher ratio of physicians to population that does England, which is operating a system of complete medical care.

Secondly, substantial numbers of our physicians are at present underutilized, particularly the younger physicians, who for the first 7 or 8 or 10 years, until they establish themselves in terms of a wide reputation, tend to be underutilized. There is a considerable slack there in terms of what we could do.

Mr. Bennett. Right there, will they not still be under-utilized under this bill?

Mr. Kingsley. I would not expect that they would.

Mr. Bennett. If this bill is passed would more people go to inexperienced doctors?

Mr. Kingsley. Of course, the implications of your final statement I would disagree with. The doctor most recently out of medical school is likely to be about as good as you can find today because developments are coming along so fast. He will not have to spend time advertising himself as he does now when you have large numbers of people able to use his services.

Mr. Bennett. Is not one of the purposes of this bill to stimulate or to make more attractive the medical profession and thus enlist greater numbers of men and women to go into the profession?

Mr. Kingsley. I would say that that is one of the purposes of the scholarship title of the bill.

Mr. Bennett. That is one of the purposes of the bill, is it not?

Mr. Kingsley. I personally think that the medical profession would be more attractive if this were adopted but I do not think that that was a motivating factor in the drafting of the bill.

Mr. Bennett. That brings up the point that I am interested in. Suppose after this law gets into operation, if it is passed, for 8 or 10 years, enough time so that we will have turned out as many doctors as we need and maybe a lot more than we would need under our present system. As I understand this bill, if a community needs 5 doctors and it has 10 doctors, under the terms of this bill the 10 doctors in that community, 5 not being needed, would be taken care of by the Federal Government under the provisions of this bill. Is that a fair statement?

Mr. Kingsley. I do not think it is. It depends how you mean "taken care of."

If they stayed in your community, say town X, 5 doctors could handle the business but there are 10 there and all 10 stay and all 10 belong to the program, what would happen in effect would be that all 10 would receive smaller payments, assuming that each of them has some patients. They would receive payments from the insurance fund but, of course, the net income of any one of them would be, the average income of each of them, would be only half as much as if there were only half as many doctors there.

So that, other things being equal those extra five doctors would not stay there.

Mr. Bennett. Is there any limit on the amount that any one community can spend for medical services based on population?

Mr. Kingsley. The limit would be determined by the amount of money available first of all in the national fund which under the present pay-roll levels would be about $5,600,000,000 which in turn would be distributed to the States and then the States can under the program, if they want to, add to the fund. In other words, they do not have to, but they can.

Mr. Bennett. Is there any limit to the amount which can be spent in taking care of the problems of that community?

Mr. Kingsley. There would be a limit in the amount of money available to that community under the State plan which would be in turn limited by the amount of money from the Federal Government to the States. There is no escalator provision in this bill through which you pay for all care that comes along. This bill would have to be accompanied by a revenue measure as well.

Mr. Bennett. You get back to where you are now, do you not—that the community's medical services are based upon its capacity to pay for medical services, is that not true?

Mr. Kingsley. That is true in speaking very broadly of the whole country. There are two differences, first of all we estimate that in fact the expenditures when the system is fully operating, the total expenditures for medical care in the country out of the whole economy, private expenditures and everything else, would be about $1,000,000,000 higher than now.

Secondly, we estimate that there would be a very substantial improvement in the utilization of health personnel and health facilities which would result in a much wider range of service so that on the one hand you will have expenditures of about $1,000,000,000 more and on the other hand you will have an incerase in efficiency due to the better distribution and better use of facilities.

On the basis of that given population, that practically would mean that full medical services could be provided as fast as hospitals are provided. To be sure, if you do not have a hospital, you cannot treat people.

Mr. BENNETT. Who is going to say what standards will be used in determining what amount a given community is entitled to pay for medical services in the community?

Mr. KINGSLEY. It is determined by the State, probably by a single State agency, probably a State health department, with the advice of a State advisory board which is provided for in the bill as to the allocation of funds.

First of all you have $5.600,000,000 collected by Internal Revenue. The National Insurance Board will allocate that to States on a per capita basis or on the basis of a number of factors outlined in the bill. The State then takes that in, breaks it down in terms of local health districts or whatever they have divided the State into. Again, I suppose they would take into acount population and so on in making those allocations.

The local committee, having a certain amount, say, $1,000,000 or $100,000, the local administrative committee composed of both physicians and consumers then determines within the local health unit what services can be provided or are to be provided out of that fund and they can do it in a number of ways. They can say, "We will not provide toupees," answering Mr. Scott's earlier question. Or, they can say, "We will provide toupees." If we had a large number of airmen who had been shot down as the British had in the Battle of Britain, burned and scarred and what not, we would probably make available toupees, but under the present circumstances I doubt that it will be done.

Mr. BENNETT. The State government has the right to determine how much any community would get to spend for medical care in this community?

Mr. KINGSLEY. Yes, sir; it is entirely a matter for the State to determine.

Mr. BENNETT. What was that?

Mr. KINGSLEY. It is entirely a matter for the State to determine.

Mr. BENNETT. Where does the Federal Government come into the picture?

Mr. KINGSLEY. The Federal Government comes into the picture in first of all, the collection of money, the allocation of the money to the States, and approval of State plans. What shall be in State plans again is spelled out in the bill. There is a requirement that State plans shall provide for an administration by the single State agency and have a merit system.

Mr. BENNETT. Is there any provision for per capita distribution by States or is that a matter of discretion?

Mr. KINGSLEY. No, the provision on allocation, as we have indicated in our report to this committee, is vague. In our judgment from an administrative standpoint it would be preferable if the committee would write into the bill much more specific standards for allocation of money at the Federal level than are in here.

Mr. BENNETT. Is it going to be distributed on a per capita basis or on the basis of need?

I have in mind that you mentioned in your testimony the State of Mississippi. Will the State of Mississippi get their money on a per capita basis or get their money on the basis of actual need for medical services in that State?

Mr. KINGSLEY. That is not wholly clear from the bill as written except for this point that there is specific provision in here to the tune of $35,000,000 in title IV for direct action by the Federal Government to create facilities and support personnel moving into especially chronic shortage areas.

Mr. BENNETT. That $35,000,000 gives the Federal Government the right to spend money in placing doctors whom they select, in any particular area of the country?

Mr. KINGSLEY. They would enter into a contract but not in terms of hiring the person. As I would read that title of the bill, they would agree, if necessary, to provide transportation for him and his family from wherever he is to wherever he is going. They would make permits for construction of property and things of that kind but he would not be a public health doctor on the public health rolls. In answer to your original question on this, there is one other point.

There is provision in here for an emergency reserve fund which after the first year is to be 5 percent of the total income collected and which can be distributed by action of the Board because it is separate to the State allocation and which again could be used in building up the shortage areas, the rural areas, as compared to the area that has a higher ratio.

Mr. BENNETT. Somebody in Government, whether here in Washington or in the State capitals is going to determine the amount of money that every community within the State needs for its medical services and hence I would say that if it has that power it also has the power to determine the number of physicians and dentists who will practice the profession in that community.

Mr. KINGSLEY. The first point, the Government would have the power to determine, somebody in Government at each level, some administrative level, would have the power to determine these allocations, that is true, but in accordance with a standard provided by Congress in the legislation as is done in all other grant programs. It is no different from the allocation of funds under some of the existing grant programs in that respect. Somebody has to decide that. It does not follow from that that they are going to decide how many doctors will be in an area except that they decide the level of medical purchasing power in the area.

Mr. BENNETT. That is it. If they decide that $25,000 is going to be spent in a given community, you could only pass that around to a certain number of doctors.

Mr. KINGSLEY. That is right.

Mr. BENNETT. Does this bill contemplate any medical service other than medical doctors? Does it take in osteopaths and chiropractors?

Mr. KINGSLEY. It provides that wherever they are licensed to practice medicine in a State then they are included, but where that is uncertain, as it is in a number of States, then the bill is uncertain.

In effect, it would be left up to each State.

Mr. Bennett. There is nothing in this bill that would exclude osteopaths and chiropractors?

Mr. Kingsley. No, sir.

Mr. Bennett. Or optometrists?

Mr. Kingsley. No, sir. Any medical personnel licensed to practice by a State could get payments from this fund. That would be left entirely to the State.

Mr. Bennett. Getting back to my original thought on this, that if either at the State level or Federal level some board can determine the amount of money that can be spent for medical services in a given community, then this Federal Board by having that power necessarily has the power to decide what communities throughout the country the medical profession shall migrate to, and live in, to a large extent?

Mr. Kingsley. I would personally put it to a limited extent rather than to a large extent.

Mr. Scott. If the gentleman would yield, you might simplify it by saying medically displaced persons' program.

Mr. Kingsley. I admire your phrase making but I do not think it is very applicable.

Mr. Scott. You will as time goes on.

Mr. Kingsley. I am sure I will hear more of it, I am certain of that.

In effect what this bill has to do with, aside from title IV is not the distribution of physicians directly but with the qualization of medical purchasing power across the country in the same way that any social-insurance program does to the extent that we reach a more equitable distribution of medical purchasing power by this means. We will in fact effect a redistribution of medical manpower which, as I attempted to point out in my statement, is one of the major problems that we have to solve if we are going to do anything. We have to do that; that is an objective.

Mr. Bennett. The more medical men you get, the more widely they will be distributed?

Mr. Kingsley. I would think so, other things being equal, although recently under the present system, the more doctors we get the more high the concentration in the northeast becomes actually, if you look at the statistics over the last 15 to 20 years, particularly in New York City.

Mr. Bennett. Every doctor that goes in under this program is under it by contract as I understand it by the bill and once he is in by virtue of the contract he is in until some board created under the bill says he is released?

Mr. Kingsley. No, I believe that is not correct, Congressman. He is in for 1 year. He contracts for 1 year at a time and he can do anything he wants to at the end of that year. The only reason that that year is from an administrative standpoint so that for a given time you know who is in and who is not in. Otherwise, he is free to be in or out or half in. Half of his patients can be Blue Shield patients and the other half need not be. There is no difference whatever in the manner in which a physician would practice or in his relations to you as a patient.

It is absolutely no different than if you belong to the Blue Shield.

Mr. Bennett. The doctor has to go under this program if this law goes through, he does not have any option?

Mr. Kingsley. I think most doctors will want to go in under the program. In the first place they will have a better assured income.

Mr. Bennett. Whether they want to or do not want to they will be forced into it; that is, the rank and file doctor?

Mr. Kingsley. Again I would not put it that way. I would say that there will be a great advantage to the rank and file doctor to come into the program because he will have an assured income and he will not have to pay a number of clerical personnel to send out his bills and so forth.

Mr. Bennett. That is not what the doctors say.

Mr. Kingsley. Which ones?

Mr. Bennett. If a doctor does not go in under this program then his practice is limited to incomes of $5,000 a year or more?

Mr. Kingsley. Substantially what his practice is now limited to, a large part of his paying practice.

Mr. Bennett. That would not be true, would it? You put this program in and then the doctors that accept the terms of the program and enter a contract will take care of presumably all of those with incomes of $4,800 or less.

So, the doctor who does not get into the program has his practice limited to patients whose income is $4,800 or more per year and are not under this legislation?

Mr. Kingsley. I think you are reading the tax-base provisions of the bill because the $4,800 here is the limitation on the amount of income which will be taxed for this purpose. It is not a limitation on the income of the people who will be covered by the plan. Everybody will be covered by the plan, or 125,000,000 people will be covered, as spelled out in the plan regardless of their incomes. But only the first $4,800 of a man's income will be taxed for that purpose; that is, the one and a half percent tax envisaged here will apply only to the first $4,800 income even if they had an income of $15,000 or $25,000.

Mr. Bennett. Self-employed people are optional in this bill. There is no compulsion for self-employed?

Mr. Kingsley. I believe as the bill now stands the self-employed are covered. As I read it that is identical with recommended coverage by the Ways and Means Committee, which has been considering old-age and survivors' insurance. I mean, the administration recommendations there provided for compulsory coverage of self-employed and I believe it is the same here.

Mr. Scott. Will the gentleman yield?

Mr. Bennett. Yes.

Mr. Sadowski. I believe Mr. Wilson has a question.

Mr. Wilson. Mr. Kingsley, let me ask you a question. It has been used several times through the witness' testimony, the figure of 120 to 125 million people that would probably be covered under this program if it becomes law. What briefly is the basis of that estimate that 120 to 125 million would be involved?

Mr. Kingsley. Yes. The groups that are covered here as I would read the bill are, first of all, all employees in the country; that is one group.

Secondly, all self-employed as independent entrepeneurs and businessmen and all self-employed and so on, including agricultural groups. Now the only part of the population that is not covered as this bill is written I would think would be people that have neither business income nor wage income; that is, people living on annuities or the indigents are not covered under the insurance program; they are covered by direct payments. You would subtract from the total population of the United States whatever the estimate of the indigent is at one end and the people living from annuities at the other end and that would give you what we have estimated at 123 or 125 million.

Mr. PRIEST. Mr. Scott?

Mr. SCOTT. Is not your bill discriminatory in at least two respects in that you have just said you are taxing to pay for the services of those with incomes of $4,800 or less and therefore you are taxing the poor as against the rich.

Secondly you are discriminating and leaving out of the bill a poor widow living on an annuity of $1,200 a year? What is fair about that?

Mr. KINGSLEY. I take it that there are two questions there?

Mr. SCOTT. There are two questions.

Mr. KINGSLEY. I will address myself separatedly to each. First of all, this bill is not discriminatory, it is not taxing the poor rather than the rich because it taxes everybody. First of all you have the same rate, 1½ percent against income. It taxes 1½ percent against income up to $4,800. It does not mean that the man who makes more than $4,800 would not pay a tax. I would pay a tax up to $4,800 of my income.

If Congress so desired, I do not know whether Congressmen would be covered under this or not; perhaps they could come in on a voluntary basis. If they did, they would be taxed 1½ percent of $4,800. The reason for that is that social insurance is based upon ability to pay and everybody pays the same rate but it varies with their ability to pay and with their income.

However, what would be inequitable in my judgment would be if you had no upper limit on it so that you would tax a man having $100,000 income 1½ percent of that.

Mr. SCOTT. What about the people in late years, say, past 50 living on annuities and presumably according to the science of geriatrics they are more in need of medical care. Where is your provision for them?

Mr. KINGSLEY. Of course there is no reason at all why you could not write in a provision to allow them to come in. It is an administrative problem and that is the only reason they are not covered.

Mr. SCOTT. Would you tell us how a doctor would get out of the program once he got in?

Mr. KINGSLEY. All he does is say he does not want to be included in the program any more.

Mr. SCOTT. How much does this program cost?

Mr. KINGSLEY. The maximum that it could cost at the present time in terms of present tax revenue and national income and population and so on would be 4 percent of, oh, about $140,000,000,000 which comes out to about $5,600,000,000. That is the maximum under this bill that this could cost. That is made up of 3 percent, half on the worker and half of the employer or 2¼ paid by the self-employed and a maximum contribution out of the general revenue equal to 1 percent of the total pay rolls.

Mr. SCOTT. One-seventh of the present national budget. Let me read something, you said the doctor could get out at any time. This is section 720 and it reads as follows:

> Any person who enters into an agreement under this part may terminate such agreement after reasonable notice and after suitable arrangements are made to fulfill professional obligations to eligible individuals.

Mr. KINGSLEY. That I believe, Congressman, should read in connection with another section which I have already referred to which provides that in any event they can get out after a year. This is really an escape provision which permits them to get out in less than a year and they have to make arrangements for the patients that they have agreed to take.

I would also like to comment briefly, if I may, upon your comment about the size of this program, $5,600,000,000. As already indicated in my statement, a very substantial part of this money is already being spent in this country. Moreover, very conservative estimates would indicate to us that at least $27,000,000,000 every year in national product is being lost through sickness and disability; that at least one-third of that could be saved by more adequate medical care. At least one-third, it is a very conservative estimate, or $9,000,000,000 of that national product. But if we did save $9,000,000,000 worth of national product, we would collect another $1,500,000,000 in Federal income taxes alone.

So, there would be no net cost to the economy as a whole and the economy as a whole would gain substantially. Even to the Federal Government viewing that as a small sector of the economy, the net cost would be substantially less than $5,600,000,000.

Mr. PRIEST. It is now 12:30 and if there are no further questions, the committee will stand adjourned until 2 o'clock this afternoon at which time the president of the American Medical Association is to testify.

Thank you, Mr. Kingsley.

Mr. KINGSLEY. Thank you, Mr. Chairman.

(Thereupon, at 12:30 p. m., the subcommittee recessed to reconvene at 2 p. m. of the same day.)

AFTERNOON SESSION

(Whereupon, at 2 p. m., the committee reconvened pursuant to the taking of the noon recess.)

Mr. PRIEST. The committee will come to order.

Before starting the afternoon session the Chair wishes to state again that 3 days of these hearings originally were designated for testimony on the over-all health bill, and following those hearings it was the intention of the subcommittee to take the bill up title by title with all related bills, identical bills, or similar bills that have been introduced. I repeat that announcement at this time because, notwithstanding the habitual announcement, most of the testimony so far has been on title VII, which is all right, and there is no objection to that; but the purpose of making the statement is to permit witnesses to know and those who are interested to know that there will be at a later date ample opportunity to discuss title VII much more fully than we can discuss it in these 3 days of preliminary discussions of the over-all bill.

So if we are unable because of the crowded schedule to give all witnesses all of the time that they would like to have on title VII, bear in mind that we will get back to that title as a separate title where testimony will be confined to that title at a later date during the hearings sometime in June.

We are happy to have Dr. Roscoe Sensenich, president of the American Medical Association, as our first witness this afternoon. Doctor, will you take the chair?

STATEMENT OF DR. ROSCOE SENSENICH, PRESIDENT, AMERICAN MEDICAL ASSOCIATION, SOUTH BEND, IND.; ACCOMPANIED BY DR. LOUIS H. BAUER, CHAIRMAN OF EXECUTIVE COMMITTEE OF THE BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION, HEMPSTEAD, LONG ISLAND, N. Y.

Dr. Sensenich. Thank you, Mr. Chairman. We are very glad to have the opportunity to confer with you. We feel that it is rather a public responsibility, just as no doubt the committee feels that it should hear people who would rightfully be interested in this.

My presentation will be as you stated, Mr. Chairman, on the matter of the general consideration of this type of legislation and does not concern itself with the individual subtitles.

My name is Dr. R. L. Sensenich. I practice medicine in South Bend, Ind., and have done so for a number of years. I represent the American Medical Association, being its president. The association, as of May 1, 1949, had a membership of 142,882 physicians.

It is my understanding that your committee today will not concern itself in any great detail with the merits of the individual titles of the legislation under consideration but that these individual titles will be scheduled for hearings at a later date. It is my further understanding that you expect the statements presented by witnesses today to be of a preliminary nature and somewhat general in scope. I do wish to present briefly for the consideration of the committee some general observations concerning the viewpoint of American medicine with respect to programs for medical care.

There is little disagreement as to the desirability of the widest possible distribution and availability of the best quality of medical care. The differences of opinion arise as to the best way to attain this objective. It is the belief of the medical profession generally that the primary responsibility for the health of the individual citizen rests on that citizen and on his immediate family. When the requirements of a particular situation exceed the ability of the individual or his family to meet them, the local community, by the American tradition, comes to his aid. Should the resources of the local community prove inadequate to deal with a volume of demands for assistance in the health field, the problem then becomes a responsibility of the State. It is only when the State in its turn is unable to cope with these demands that there should be recourse to Federal assistance. We believe that this procedure is in accordance with sound American tradition, with the intent of our political principles, and with the maintenance of self-reliance and independence in each of these levels of relationship, from the citizen to the National Government.

It follows that the local community or the State should make provision for the supplying of medical care to those of its citizens who find themselves financially unable to procure needed services. It is customary to speak of such economic groups as the indigent or medically indigent. It is believed that a simple system can be set up by which those falling into these groups may seek the services of any reputable physician and that such physician may be recompensed from public funds in accordance with an established fee schedule. Perhaps it would be necessary in order to prevent abuse that a welfare department or some other investigating agency of the political unit should certify to the propriety of covering the specific case, under the provisions of the system.

Such a system is not merely a theoretical proposal. It is already in practical operation and it is proving generally satisfactory. There may, of course, be other types of organization and wide diversity in detail in the methods adopted to meet the health problem at the local and State level. The point of importance is that the responsibility lies here and should be recognized and so far as possible met at the local and State level. Only when these political subdivisions have made full effort and fall short of accomplishment should recourse be had to Federal assistance.

Under such circumstances it may become incumbent on the Federal Government to support the State effort. This support may take the form of supplying advice, experience, expert personnel on a loan basis, or financial aid. Before financial aid is granted it should be established that the individual State has made genuine efforts to solve its own problems, that its health program is soundly conceived and efficiently operated, and that only lack of funds as evidenced by the general economic condition of the State is the reason for the need of Federal financial assistance. Nothing in the relations set forth, however, should imply that the Federal Government should assume the right to dictate a single system of medical care for all States, nor to attempt to control the appointment of personnel in the State plans nor otherwise to exercise improper interference. There should perhaps be a recognized percentage limit, as relative to the total cost of a State plan, beyond which Federal financial aid could not be extended.

It will be seen that this conception of the relation of the Federal Government to the provision of medical care to the least favored economic groups is that of a stand-by support of the State programs. It would place primary responsibility and initiative on the State and local governmental divisions. It would prevent dominance of the local authorities from Washington. It would limit interference in State plans to the approval of their adequacy and efficiency. It would make the need for financial assistance and the amount of such assistance dependent on the economic status of each particular State.

From what I have said, it will be obvious that any plan for Federal participation in the handling of the problems of medical care that lodges primary initiative and control in Washington, that contains uniform and compulsory features on a Nation-wide basis, and that lays a direct Federal tax on citizens generally to finance the program is unacceptable in principle. Such plans concentrate further power in the Central Government, they absorb in Washington functions much better retained at the local level, and they greatly enhance the overall cost of providing health services. Most important of all, they would lead to a widespread and serious deterioration of the quality of medical care.

The provision of medical services to the indigent is not all of the problem that faces us in the matter of general adequate medical care. There is a large group, above the level of medical indigents, who yet find the professional service cost of a serious illness a grave financial problem. These people need security against such calamities and it is the accepted idea that the insurance principle is the answer to the problem, but it should be voluntary insurance. There is no justifiable reason for assuming that these people are minors or incompetents and compelling them by Federal law to participate in a Nation-wide system of prepayment for so-called health insurance. Leaving aside any questions as to the Government being able at this time to deliver the services promised and paid for under such a scheme, it constitutes an example of compulsory paternalism, wrong in principle, impossible of practical operation, and contrary to our established ways and habits of life and political principles.

This is not meant to imply that effort is not needed to stimulate the widespread development of voluntary prepayment plans for insurance against the professional costs of serious illness. Such plans already have an extensive existence and are spreading rapidly. They deserve the wholehearted support of all who are honestly interested in this problem. Such plans are actuarially sound, are well managed and backed by a medical profession ready to accept some financial sacrifices, if necessary, for a large public good. There is no reason, after the experimental period has passed, why such plans should not be self-supporting. The only question of governmental aid, either State or Federal, might concern certain marginal financial groups and certain short initial developmental periods.

The council of medical service of the association, created by the house of delegates in 1943, has conducted a continuing study of proposed programs pertaining to the economic, social or other similar aspects of medical care, has suggested improvements in such programs and has made available all information that it has been able to assemble. The council has taken the initiative in assisting in the promotion of voluntary prepayment programs. The term "assisting" is used advisedly because much of the actual promotion must be done at the State and local levels, by the plans themselves, by the medical societies and by physicians. I would like to leave with the commmittee a copy of a brochure prepared by the council, revised as of 1948, which contains detailed information with respect to the various medical-care-voluntary programs that are in existence at the present time in 43 States. If, during the course of these hearings, members of the committee wish further testimony with respect to the plans themselves, the association will be only too glad to make that information available. Suffice it to say here that approximately 57,000,000 people have hospitalization coverage and approximately 30,000,000 have surgical coverage, both as a result of voluntary action on their part.

The association has now completed over 100 years of organized existence. During these years it has developed an ever-expanding program with a view to charting a safe and sure road toward the advancement of the Nation's health. It has directed continuing study and experiment to improve methods of undergraduate education in medicine, the organization of opportunities for postgraduate study and the creation of facilities for the provision of the best medical care including service to the indigent and those of low income.

The direction of these efforts throughout the whole field of study and the improvement of standards and methods have been characterized by close contact and cooperation with the health activities of governmental agencies, Federal, State, and local; educational and research institutions, voluntary groups; and some philanthropic health agencies. It has observed closely the standards and method of distribution of medical care of other nations and has had the benefit of the experience and advice of unselfish investigators trained in the direction of health activities throughout the world.

These broad considerations of the problem of the best possible health for all the people has led the association to prepare a basic outline for continuing development and action. This is known as the Program of the American Medical Association for the Advancement of Medicine and Public Health. This program embraces 12 major points or planks, some of which have been advocated by the association for many, many years. This program follows:

A FEDERAL DEPARTMENT OF HEALTH

1. Creation of a Federal Department of Health of Cabinet status with a Secretary who is a doctor of medicine, and the coordination and integration of all Federal health activities under this Department except for the military activities of the medical services of the armed forces.

MEDICAL RESEARCH

2. Promotion of medical research through a National Science Foundation with grants to private institutions which have facilities and personnel sufficient to carry on qualified research.

VOLUNTARY INSURANCE

3. Further development and wider coverage by voluntary hospital and medical care plans to meet the cost of illness, with extension as rapidly as possible into rural areas. Aid through the States to the indigent and medically indigent by the utilization of voluntary hospital and medical care plans with local administration and local determination of needs.

MEDICAL CARE AUTHORITY WITH CONSUMER REPRESENTATION

4. Establishment in each State of a medical care authority to receive and administer funds with proper representation of medical and consumer interest.

NEW FACILITIES

5. Encouragement of prompt development of diagnostic facilities, health centers and hospital services, locally originated, for rural and other areas in which the need can be shown and with local administration and control as provided by the National Hospital Survey and Construction Act or by suitable private agencies.

PUBLIC HEALTH

6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable-disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

MENTAL HYGIENE

7. The development of a program of mental hygiene with aid to mental hygiene clinics in suitable areas.

HEALTH EDUCATION

8. Health education programs administered through suitable State and local health and medical agencies to inform the people of the available facilities and of their own responsibilities in health care.

CHRONIC DISEASES AND THE AGED

9. Provision of facilities for care and rehabilitation of the aged and those with chronic disease and various other groups not covered by existing proposals.

VETERANS' MEDICAL CARE

10. Maintenance of existing high standards of medical care for veterans, including extension of facilities where the need can be shown and, where practicable, care of the veteran in his own community by a physician of his own choice.

INDUSTRIAL MEDICINE

11. Greater emphasis on the program of industrial medicine, with increased safeguards against industrial hazards and prevention of accidents occurring on the highway, home, and on the farm.

MEDICAL EDUCATION AND PERSONNEL

12. Adequate support with funds free from political control, domination and regulation of the medical, dental, and nursing schools and other institutions necessary for the training of specialized personnel required in the provision and distribution of medical care.

Is the health of the American people in such a low state as to necessitate revolutionary remedies, or proposed remedies, to be made available by the Federal Government as contemplated by the legislation pending before your committee? What actually is the record of our health progress under the system that prevails in the United States?

In 1900, 1,000 babies—white and nonwhite—were destined to live the aggregate 49,000 years. One thousand babies born in 1949 are destined to live an aggregate of 68,000 years. Even among nonwhites, whose living conditions and health standards are admittedly lower than those of the white population, the years to be lived increased from 34,000 to 61,000. In terms of life expectancy at birth, the average for the whole United States population has risen from 49 years in 1900 to 68 years in 1949. Health progress certainly must have been enjoyed by all segments of our population in order to achieve this progress.

While the population of the United States has doubled since the turn of the century, from 75,000,000 to 150,000,000, the number of people over 64 years of age has quadrupled, 3,000,000 to 12,000,000. The increase in the average age of the population caused by the increased number of old people is reflected in the fact that while, in 1900, only 4 out of 12 funerals were for persons over 50 years of age, today 9 out of every 12 funerals are for persons who have lived a half a century or more. Health progress, in other words, has raised the average age at death. The older half of the people dying in 1900 had lived 30 years or more. At the present time half of the people dying at last have lived 66 years or more. Medical progress, therefore, has succeeded in allowing more and more people to live on to higher ages.

Maternal mortality rates are another example of progress. In 1933, the United States ranked 11th among all nations in maternal mortality, with 6.2 deaths per 1,000 live berths. In 1947, the rate had declined to 1.3 deaths per 1,000 live berths (see the Journal of the American Medical Association, vol. 140, No. 1, p. 113, May 7, 1949). Unless Sweden—and perhaps Denmark, England and the Netherlands—had a lower rate in 1947, and data for 1943 are the latest available in these countries, the United States probably ranked close to the lowest record in material mortality in all nations in 1947. It is of equal importance that the State having the worst record in 1947 of 2.6 deaths per 1,000 live births, had a maternal mortality rate of less than two-thirds of the rate of the best State in 1933 of 4.3 per 1,000. Thus health progress has, at least by these indicia, been general throughout the United States.

It is acknowledged, I believe, by the advocates of compulsory sickness insurance that our health progress has indeed been remarkable but it is claimed that, among other things, 325,000 deaths from enumerated causes could be prevented each year and it is inferred that this prevention can be accomplished only by compulsory sickness insurance under Federal direction. Some proponents of compulsory health insurance propose to reduce the number of deaths from communicable diseases annually by 120,000, from cancer and heart disease by 115,000, from fatal accidents by 40,000, from conditions relating to infancy and maternity by 30,000 and from other causes by 20,000.

With a continually increasing population the number of deaths must increase. The rising number of deaths from heart disease and cancer is actually a result of medical progress. Modern medical science has saved men from death from pneumonia at 35, but these men will eventually die of heart disease, cancer, or some other cause. The physician can change only the cause of and age at death. He can never absolutely prevent death.

Maternal mortality has already been referred to and infant mortality shows similar progress. In 1920 we ranked ninth among the leading nations of the world in infant mortality counting our nonwhite population. And it should be noted that many of the other countries used in this comparison here have a relatively small nonwhite population. Thirty years later, in 1950, we will have progressed to third or fourth rank.

What about deaths from communicable diseases and accidents? Deaths from communicable diseases have showed a consistent decline but such deaths are fostered not so much by the lack of availability of medical care as by poor and overcrowded housing, lack of strict enforcement of sanitation laws, and inadequate education of the public in general health matters. Deaths from communicable diseases, therefore, are not solely a medical problem.

Accidental deaths are not primarily a medical problem, either, but today fatal accidents cut off more years from the working lifetime—age 20 to 65—of the American people than the condition that causes the most deaths, heart disease. The average age at death from heart disease is 67 years while the average age at death from accident is 46 years. Medical care is almost always available to badly injured persons and most deaths occur soon after the accident. The task of preventing accidents lies with the safety directors and educators and not with the medical profession solely.

Much has been said about the alleged shortage of physicians. Those who contend that there is a shortage base their contention on the fact that the 12 States that have the largest number of physicians per 100,000 population, 150 physicians, represent the desirable norm and that all States should measure up to this norm. On the basis of this mechanistic formula, it is forecast that in 1960 there will be a shortage of some 42,000 physicians. It is predicted, by those who advance these contentions, that at the present rates of production of physicians there will be 212,000 active physicians by 1960 and to meet the standard percentage obtaining in the twelve best States, there will be needed by that year 254,000 physicians.

The formula that forms the basis of these estimates assumes that the same percentage of physicians per 100,000 population is desirable and necessary in every State and leaves out of consideration that in the so-called 12 best States, a large number of interns and residents in teaching centers may unduly increase the physician population of the 12 best States.

Even if 42,000 more physicians could be trained by 1960, and assuming that such an increase is necessary, there could be no assurance that the excess number of physicians would locate in States that do not measure up to the average physician population obtaining in the 12 best States. It is true that although the construction of hospital facilities and diagnostic clinics authorized by the Federal Hospital Survey and Construction Act may make the less remote areas attractive to more physicians, there are many more factors that influence the location of physicians than hospital and diagnostic facilities, such as schools, and opportunities to maintain professional contacts so necessary in the practice of medicine.

Furthermore, since 1940 the population has increased 13 percent and the number of physicians has increased 15 percent, so the relative number of physicians to the population has increased rather than decreased. The number of physicians practicing in a given area does not necessarily represent the supply of medical care available. Where once the physician carried on alone, much of the routine work today is assumed by technical assistants, nurses, and research workers.

This situation automatically enables a physician to do a greater volume of practice and the conveniences of transportation enable him to cover a much wider territory.

It has been said, too, that 80 percent of the American people are unable to afford all of the medical care they need. This statement by implication assumes that the only type of economic goods or services purchased by the American people is medical care and overlooks the fact that the purchase of medical care is a matter of free choice for the majority of the people.

The fact is that we live in a free society where the consumers are the dictators so far as the commodities that they choose to purchase and the commodities that they do not purchase are concerned. In the past the decision of the consumers has been to spend 96 percent of their income for items other than medical care. They have decided that they can afford 1¼ times as much for alcoholic beverages as for medical care and another 1½ times as much for recreation. They have decided they can afford twice as much for tobacco as for the services of physicians. They have decided they can afford considerably more for personal care than for doctors' care. They have decided they can afford about as much for jewelry and repairs of watches and clocks as for physicians.

These were not the decisions of the medical profession nor of any other group offering medical or allied services but they were the decisions of 147,000,000 people. If we must be frank, the American people spent only 4 percent of their income on medical care, not because they did not have more to spend, but they preferred to spend 96 percent for other purposes.

I shall not undertake to explore in detail the cost of a comprehensive system of medical care as contemplated by the pending legislation. I believe that it is anticipated that initially the system will be financed by pay-roll deduction plus appropriations from the general funds. Estimates by competent actuaries place the cost from $10,000,000,000 to $15,000,000,000 annually.

The assumption has been made that there is a financial barrier between a very large part of the public and the medical service they need, but this barrier in the main relates to ablity to pay for large and unexpected expenditures incurred for medical needs. This is a situation that is being overcome progressively by the rapid development of private health insurance plans. Although the provisions of these insurance policies vary greatly, in general they do permit the family to budget the major costs of medical care.

It is true that all types of medical-care coverage are not available throughout the United States and that some are available only to members of the employed groups, but progress is being made toward complete coverage. The cost of such coverage varies, of course, with the benefits made available. A family may, for instance, purchase a typical Blue Cross-Blue Shield membership which will pay the bulk of hospital and in-hospital medical bills of 20 cents a day, the price of a package of cigarettes or a bottle of beer.

In return for the money spent on medical care, the American people have received a truly phenomenal measure of health. During the 1940's the medical profession delivered an extraordinarily high quality and great quantity of medical care at an extremely low cost. While the cost-of-living index of the United States Bureau of Labor Statistics in 1948 was 171.2, the index of medical-care prices was 141. In other words, the combined average prices charged by physicians, dentists, and by hospitals has not risen as fast as the cost of living.

It is abundantly clear that the cost of medical care has risen during the 1940's in terms of dollars, but the percentage of the consumer budget taken by medical care has not risen. Meanwhile life expectancy at birth and at every age has risen. This triumph of medical economics, steadily increasing life expectancy at the same percentage cost of the consumer budget, may well be the major contribution of medicine in the 1940's. The 4 years of life expectancy at birth gained in the last decade alone mean many millions of dollars earned and the chance of a good life for many more people than ever before.

Yet in the midst of all this health progress, it must be remembered that medical care can never be wholly adequate as long as pain comes too often and death too soon.

Mr. Chairman, if I may call attention to it, I was a bit astounded when I ran over the figures at the top of page 13. We evidently missed some ciphers on that.

Mr. BIEMILLER. You obviously mean billions instead of millions.

Dr. SENSENICH. Yes.

Mr. HALE. A quite common mistake in Congress.

Dr. SENSENICH. A quite common error. I am sorry.

Mr. PRIEST. We thank you for your statement. I have just one or two questions of a rather general nature applying to titles in the bill other than compulsory health insurance.

Title I in this bill is the title that will provide aid for medical education and health personnel. Would you care to state whether you personally or the AMA approve of the general purposes of that title?

Dr. SENSENICH. As to the general purpose there in the matter of assistance to medical education, I am sure we would all have the same objective. There is no question about that, that the medical schools will need some additional support, some which they were accustomed to getting by gift of one kind or another over a period of years. Along with that, the actual cost of medical education has risen greatly. Their facilities are not great enough, their buildings are not great enough. Going beyond that, they need teaching staffs. Teaching staffs with additional students means greatly increased costs.

The Council on Medical Education and Hospitals of the American Medical Association is reviewing the whole matter of medical education at the present time, both for reasons of studying the processes and whether we are doing the best teaching we could do in the matter of the subjects that are taught and the facilities whereby the teaching is carried on, and as to what the costs will probably be and also with reference to any additional student needs.

With that in mind and those figures available, then it will be possible to arrive at some kind of basis for assistance. It may possibly be true that they may require assistance from governmental sources. The statement has been made, or rather the implication has been left that we were not having any medical education or that we were not making any increase. That isn't the actual fact. As a matter of fact, in the last few years we have added about nine medical schools. We have added or have increased, for instance, schools that formerly up to this time have given 2 years of medical education. There are several of those in the State schools where they now are completing the entire 4 years of the course.

That means that the students who otherwise would have been transferred to other schools for that terminal period of 2 years now are being taught in the schools in which their education began, and the other schools will for that reason have additional facilities.

Mr. Biemiller. Will you yield at that point?

Dr. Sensenich. Yes.

Mr. Biemiller. I would like to ask a concrete question on the statement you have just made there. I know of a case, for example, of a young man who completed 2 years of his medical training and, as I am informed on the case, with excellent marks. He was then unable to get into a school for the continuance of that. He became a dentist and passed his dental work with a very high mark. He now is trying to get back in medical school and he tells me he can't find a spot. I am asking, is that a common thing? Is that the type of problem that you run into very often?

Dr. Sensenich. Frankly, Congressman, that is the first one I had heard of of that type. It is true that in the transfer from one school to another there are times in which young men had difficulty making the transfer. In fact, the set-up of having two whole years of school and then turning the man loose on his own to seek another connection was a bit unfortunate, because the other school had its own classes in process and most often was not able to expand sufficiently in the senior years to take on any large number of students.

The whole situation of medical education of course was upset by the war. You are all familiar with that.

Mr. Biemiller. It was one of those casualities.

D. Sensenich. Then, too, Mr. Biemiller, when the war was over and these boys came back, the GI's had a preference in the school and for the time being the schools were badly pressed to take on as many students as they could and as many as their facilities and teaching staff would make possible. That matter is improving. Of course, it is unfortunate that during that time students had difficulty in getting in and so now the long waiting lists that we hear of from time to time are to a considerable extent fictitious because I am called upon, as no doubt many of you are from time to time, to make recommendations for these students, and then we find that every boy applies to about five or six schools because he fears that he won't make one and feels that he might make the other. That, too, Mr. Biemiller, is in process of study.

Mr. Biemiller. I would like to make the brief observation that I very much hope when we come to that title of the bill we will be able to have some advice from the American Medical Association.

Dr. Sensenich. Yes; we will have a representative here.

Mr. Biemiller. I think we have an area of agreement there at least from which we can work something out.

Dr. Sensenich. That is right.

Mr. Wilson. Mr. Chairman, I notice in the witness' statement he has a brochure he wants to leave.

Dr. Sensenich. Yes.

Mr. Wilson. I assume that will contain detailed information about voluntary plans. I would be interested to have that while he is still on the stand.

Mr. Priest. By all means, if they are available.

Dr. Sensenich. I have only one. It was to go in the file. We can get additional ones for you.

Mr. Priest. Could you supply us with others?

Dr. SENSENICH. Yes, I will be glad to see that each member of the committee is supplied.

Mr. PRIEST. Then, to proceed with one or two more questions, I shall not use more than my 5 minutes, I hope, for questioning.

I asked you about title I, and I think we are in pretty general agreement that this is a field where something needs to be done.

Dr. SENSENICH. That is right.

Mr. PRIEST. I have one question to clear my mind on an answer to a question that was asked earlier. Does this plan of a 2-year school and then a transfer to another school for two more years include the regular 4 years of medicine, or premedical?

Dr. SENSENICH. That is the 4 years of medicine.

Mr. PRIEST. The four regular years following the premedical course?

Dr. SENSENICH. Yes. That largely arose, Mr. Priest, at an earlier time when there were schools a part of whose course was offered as being basic and connected with the scientific in a university in a community which at least at that time felt they did not have sufficient clinical material. You know a medical student has to see patients. In small communities, with small populations, frequently they didn't have the clinical material, they didn't have the patients and they couldn't teach things adequately. With time going on and with a larger interest in the scientific diagnosis and that sort of thing, and with provision in many States whereby they concentrate clinical cases in these universities, some that earlier were not able to carry on a 4-year course now are doing that.

Mr. PRIEST. Without asking specific questions on the other titles, may I assume that you favor development of medical research? I believe you mentioned your support of the National Science Foundation bill, which provides for that.

Dr. SENSENICH. Yes.

Mr. PRIEST. This bill also contains a title for some research modeled along the lines of the Cancer Institute and the Heart Institute in the Public Health Service. Generally, do you support those provisions?

Dr. SENSENICH. We support that objective. I am not familiar, Congressman, with the details of some of those provisions. We supported and actively supported the other research-foundation bill. We regretted very much when it was vetoed. On the other hand, it was vetoed apparently for reasons other than the purely scientific side. We are hoping that that legislation can be accomplished at an earlier time.

Mr. PRIEST. I shall not take further time at this time for questioning because other members of the committee have some. Mr. Sadowski?

Mr. SADOWSKI. Doctor, what State pioneered the Blue Cross and Blue Shield system?

Dr. SENSENICH. I am sure that the State of Washington was early. I can't say that they pioneered it. I wouldn't want to answer that question definitely.

Mr. SADOWSKI. I understand it was the State of Michigan. Am I correct in that?

Dr. SENSENICH. The State of Michigan was very early. May I just in comment on that say that those things arose out of advanced thinking on the part of the profession, cooperation on the part of the public, and I am sure that my friends up in the good State of Washington would say, because they had too much contract work going on in the timber country up there, which the men actually complained about. Contract work has never been very satisfactory.

Mr. SADOWSKI. The Michigan State Medical Society has the reputation of being quite a progressive organization among your profession; is that correct?

Dr. SENSENICH. That is right.

Mr. SADOWSKI. I believe that they did also pioneer in research work in rheumatic fever, control work, and in postgraduate facilities for doctors, and the care and treatment of epileptic children.

Dr. SENSENICH. That is right.

Mr. SADOWSKI. They also set up the first central blood bank to make plasma available to communities which had no facilities for storing.

Dr. SENSENICH. That is right.

Mr. SADOWSKI. The AMA convention was held in Chicago last February; is that correct?

Dr. SENSENICH. We had a meeting there; yes. Not our convention, but we will say a meeting. If you will ask me further, I can identify it.

Mr. SADOWSKI. My understanding is that the Michigan Medical Society came down to that meeting in Chicago with a rather constructive program, a program which would put the American Medical Association in the position of sponsoring good legislation and taking forward steps in medical advancement for the people of the country. I understand that that was laid out in a series of eight questions. The first was, should voluntary health and hospital-insurance premiums be paid by Government during periods of unemployment?

Second, what is our policy for financial assistance to families during sickness of the wage earner? Should he have insurance? If so, who is to pay for it, and for how long?

Third, what is the policy for medical care to areas unable to support a physician? Are we in favor of assigning doctors to these areas?

Fourth, do we favor the building of health centers for treatment in blighted areas?

Fifth, do we favor State financing for building small health centers and hospital facilities in areas unable to attract a doctor? To what extent do we favor Federal assistance?

Sixth, do we favor medical benefits for the aged and chronically ill in addition to old-age benefits?

Seventh, do we favor home town care of the medically indigent by physicians of their own choice, using the same technique for care as the Blue Cross and Blue Shield have used with indigents?

Eighth, do we favor return to an individual of all money spent for medical and hospital care which exceeded 10 percent of his net income, same to come from the general fund, thus guaranteeing that no man would be forced to spend more than 10 percent of his income for catastrophic illness?

I understand that that program, which was quite thought-provoking and quite a constructive one, a lot of constructive suggestions are made here, was presented to your meeting in Chicago by the Michigan Medical Society. What did your national association do with these suggestions?

Dr. SENSENICH. Let me clear that up immediately. The house of delegates of the American Medical Association determines its policies. The house of delegates is made up by elected representatives from the various States in proportion to membership. So there is really a democratic selection and these men represent them, and Michigan is represented in the house of delegates. But only the house of delegates determines policies. There has not been a meeting of the house of delegates since that time. The house of delegates will meet in the city of Atlantic City. They meet twice a year. It is regularly arranged. They meet early in June, and then they meet along midyear. That is what is called the interim session. The delegates from the State of Michigan can submit that program to the house of delegates on the 6th or 7th of June, this being this coming June, and it will receive consideration. That is about 2 weeks away.

No one else can determine the answer to those. In taking them up individually, if we had the time, I could give you possibly the impression relative to some of them, but after all if they are basic policies, then they must be determined by the house of delegates.

Mr. SADOWSKI. That is all.

Mr. PRIEST. Mr. O'Hara?

Mr. O'HARA. Doctor, coming back to one question which has bothered me, and I don't mean to labor it, to what extent have the medical schools increased their authorized attendance in the last 10 years?

I appreciate that that takes in the war years. I am concerned about the limitation that has been imposed upon the number who may enter some of our largest and finest medical schools.

Dr. SENSENICH. There have been no restrictions in number except by the facilities of the school itself. I am glad you brought that up, Mr. O'Hara, because by implication from time to time someone tries to convey the idea that the American Medical Association or the medical profession are restricting the number of graduates of medical schools, which is not true.

Mr. O'HARA. It is true that that impression exists.

Dr. SENSENICH. That is not true, Mr. O'Hara. We have no control whatever over the universities so far as their admission of students. That is a matter of their own concern. The only control there would be, and that comes back to the time when they reviewed and cleaned up and fixed the standards of medical schools a good many years ago, and since that time schools have had to satisfy the general level of medical education.

In other words, a school that had the facilities, the microscopes, and the laboratory facilities, and the other facilities built for 100 students, obviously could not accept 200 students and do justice to those students. Those are the only restrictions. There is no limitation otherwise from any source.

Mr. O'HARA. Is your school Indiana, Doctor?

Dr. SENSENICH. No. I am from the University of Chicago, the Rush Medical College.

Mr. O'HARA. To what extent have the large State medical schools increased their admissions in the last 20 years? Suppose it was 100 or 150 or whatever it may be. It is rather limited as compared to other schools, such as law or dentistry; isn't that true?

Dr. SENSENICH. I have those figures, and the figures also of those have been published. I think that there were 16,000. I can tell you in a minute, taking the figures from this. I didn't know we were going to discuss it.

Mr. O'Hara. I did not mean to labor the point.

Dr. Sensenich. That is all right. I am glad to be of help, if I can. I can give this to you in a moment. In the 5 years from July 1937 to June 30, 1942, there was a net increase of 6,820 physicians. From July 1, 1942, to June 30, 1947, the last 5-year period, 32,877 physicians were graduated and 16,433 died, making a net increase of about 16,442 physicians for that period of time.

Mr. O'Hara. The reason I asked the question, Doctor, is based upon the concern which has been expressed so many times publicly and in this hearing as to the necessary number of doctors. Out in our own State, for example, a lot of publicity originated out of the fact that there was one town of considerable size that didn't have a doctor. There was a DP doctor who had been admitted to this country, not to practice medicine, but under the immigration laws, as I understand it. Of course he ran flat into the State laws of my home State. First, he had to be a citizen and, second, he had to be a graduate of some recognized medical college.

I don't know whether he is ever going to qualify or not. It is impossible to know. We do have a shortage of doctors, and I think that is true.

Dr. Sensenich. The town is still without a physician?

Mr. O'Hara. So I understand, sir.

Dr. Sensenich. There are two things about that that need to be borne in mind. The number of physicians has increased. I noted an increase of that much over a period of years, which is in excess of 3,000 a year over and above. One has to have in mind the fact that there is very much less illness in proportion to the population now than there once was. My father was a physician, and I think my medical education was paid for by typhoid-fever patients. Each summer nearly everybody had typhoid fever. That is a thing of the past. The typhoid-fever patient now is a curiosity. Everybody comes in to see him. We have difficulty demonstrating that case to students.

Beyond that, pneumonia, for instance, used to have a mortality of 50 percent, and those who survived that period were ill a long time. In our time pneumonia has descended down to a fraction, two-plus. And they are ill only a short time. We don't have the amount of nutritional diseases we had. We have some malaria following a war and with our travel, but not anything like the old times.

That is true clear across. Our people are better fed, they have a wider variety of food, better-balanced food in the main than they had a long time ago. Then they had only farm food that could be prepared through the winter. Now they have vegetables and all those things.

Now we have less illness than we had then. Unfortunately the impression is that at certain times in certain communities they are greatly in need of a physician because they had a physician for many, many years and now they do not have. Medical science has progressed so that there are a great many patients that cannot well be taken care of outside of hospitals, so the tendency will be probably to regional hospitals. A patient down at the corner here can be transported 20 or 30 miles to a hospital probably with less stress upon him than he can be taken across the city of Chicago or New York to a hospital where they have plenty of facilities. By so doing he goes where they have a pathologist, they have X-ray, and they have all the things necessary and the trained people to take care of them. Some of those little communities still complain because they don't have a physician resident there, although if they actually had a physician resident there, there would not be enough for him to do to make it justifiable.

Just one word more in passing, and that is that we are concerned, as you are, Mr. O'Hara, in the distribution of physicians. We want to go into those under your Hospital Construction Act and give those people leadership. In many places they have plenty of finances and with a little help and direction, we will have the facilities that will make it attractive and make it possible for a modernly trained physician to go in there and do good work.

Unfortunately, as it is, frequently the student goes to medical school in a large city, Mr. O'Hara, and he is accustomed then to all the best facilities to do with, and he meets a city girl who wouldn't live in the country under any circumstances and even if he has been financed, the idea of going out to a rural station then doesn't appeal to him.

Mr. O'Hara. Doctor, that is true, but I still think of the problem up in our section of the country, where we have people who are not concerned with having socialized medicine but are concerned with having a doctor.

Dr. Sensenich. That is right.

Mr. O'Hara. Some of those communities have some fine little hospitals.

Dr. Sensenich. That is right. Yes; it is grand and we want more of just that kind of area.

Mr. O'Hara. Doctor, one thing concerns me, and I certainly have about as much liking for the term "socialized medicine" as even you have. On the other hand, Doctor, there is this problem. That is the ploblem of meeting the cost of a serious illness which faces any one of us. Certainly it is a problem which I think is one that concerns not only the medical profession but those of us in Congress and every individual who is concerned about problems.

Dr. Sensenich. That is right.

Mr. O'Hara. Doctor, do you in any way, in any measure, endorse the theory of title VII of this bill that there is a need for so-called governmental health insurance?

Dr. Sensenich. Compulsory?

Mr. O'Hara. Yes.

Dr. Sensenich. We do not believe that that is necessary. Not only do we not believe it necessary, but we believe it would be bad. I say that and I say it without hesitation. I have visited these places. I know them. I know the areas in Europe before the war. I know the levels of medical health at that time. I did some work there. I have been in them several times in the past 2 years. There isn't any question in the world that the quality of medical care deteriorates. The incentive is gone. They are governed and controlled with a lot of directions that are time-consuming. The individual patient can demand as much service as he likes, which means that the individual physician is the insurer. He accepts so many people on his panel, and then he hopes that they won't ask too much of him because if they all ask all that they may ask, he can't possibly do it. The last thing, which is most deadly of all, is the one that is not immediately apparent, but the field under those circumstances is so difficult and so unattractive that the better minds, the better young men, are not interested in it and so they don't go into it. Over a period of time you have a gradual deterioration to a very mediocre service.

Mr. O'Hara. Doctor, have you had an opportunity to observe the operations of the so-called socialized medicine in operation in England?

Dr. Sensenich. Yes.

Mr. O'Hara. What is your observation as to the quality which even a good doctor gives to his patients, or what the doctors themselves admit, whether it satisfies their own conscience as to whether they are doing the type of job to which they think their patients are entitled, where they have a large panel, so to speak?

Dr. Sensenich. It differs, of course, as to the immediate reaction. You must remember that they have had socialized medicine over there since we came back from World War I. There are certain areas in which it went on very much the same way. I could now describe some of the areas which we in our own country would not be satisfied with. We feel that conditions are not good there. These men have had nothing to lose by the institution of the new service. They have an area, and that limit is pretty large. They will permit only so many to go in, which means the individual must have a heavy panel. Those men at the present time and that community are not accustomed to any kind of medicine such as we consider medicine. There are areas I have been in over there that actually—and I don't say it unkindly to the English because I have many friends there—but we wouldn't accept those conditions in this country as being good medical care.

True enough, on Harley Street in London, in some of the centers where they have had good specialists, and they do have good doctors there, up until the influx of the more recent bill they had mixed service. The individual had a panel and he also did private work. Frankly, the panel work wasn't probably quite as well done as the other work was done, not by any intent on the part of the physician but because they demanded a lot of things that were more or less secondary. Since the new law has been gone in, it has practically taken over the whole of medical practice. They have taken over the hospitals and with the hospitals, the endowments. While it is said that there can continue to be the same kind of private practice, they immediately said when they were asked, "Will private practice continue?" "Yes, yes, yes." "Well, how will private practice continue? Can the man in private practice get his patient into a hospital?" Whereupon, Atlee said, after all, His Majesty's Government would not feel responsible for the maintenance of private practice, and therefore if the hospital beds were needed for the patients in the Government program, then they would have priority and the private practitioner could not get a patient in, and that was the end of that.

Their hospitals are inadequate in number and in beds, and therefore even those on the panel wait a long time to get in and the others don't get in at all.

Mr. O'Hara. They do not have private hospitals at all, Doctor?

Dr. Sensenich. They have nursing homes over there. I don't know whether you are familiar with it or not. We don't have anything like it here. They have the public hospitals and the endowed hospitals, and then they have the nursing homes which are privately owned, usually small institutions. What is going to happen to them I don't know.

Mr. O'Hara. What happens to the private patient who needs an operation? What happens to him?

Dr. Sensenich. He waits like the rest wait, only longer.

Mr. Priest. Mr. Biemiller?

Mr. Biemiller. Mr. Chairman, I have a lot of matters I would like to take up. Let me start first of all with this. I would like some information, Doctor, about what has happened to the $25 contribution, I believe you called it, which you originally estimated you would raise 3½ million. What is the status of that program at the moment?

Dr. Sensenich. As to how many have paid? By the way, it was a contribution. It wasn't compulsory. I can't say at the moment. I can't tell you. It is progressing very, very rapidly. It is coming along. It has not been pressed upon the older men who have retired and those who were not able to pay without hardship. They have not been required to, have not been requested to. There was a limited number, some 138 or something like that, who protested, and some of those, quite a number of them in fact, have since made their contribution for their own particular reasons. It is being very well paid. I can't tell you the exact figures yet.

Mr. Biemiller. Those funds, as I understand it, are to be used to develop what you call an educational campaign, sending out literature and so on stating the views of the AMA on this controversial question.

Dr. Sensenich. That is right.

Mr. Biemiller. And also, as I understand it, you have now had your public relations firm register as lobbyists under the La Follette-Monroney Act, so I noticed in the last registration. That is the firm of Whitaker & Baxter which is now registered under the Congressional Reorganization Act as lobbyists.

Dr. Sensenich. The representative of our Washington office has been registered under the Lobbying Act for a period of years. It is not the purpose of this public relations firm employed at the present time to do lobbying, but on the other hand, I think from the discussions that I hear around Washington from time to time the question of what constitutes lobbying is sufficiently debatable that if you are going to do anything that has to do with public issues, you might be liable, and for that reason I presume they thought it wise to register. They are employed by us, but that is up to them, the lobbying.

Mr. Biemiller. Have the activities of the American Medical Association been tax-exempt under the income-tax law?

Dr. Sensenich. Yes.

Mr. Biemiller. Are you sure that you are going to be able to continue that way with this new fund being raised for political education or political purposes?

Dr. Sensenich. Do the labor unions?

Mr. Biemiller. They are also tax-exempt, that is true, but they don't use their funds for political purposes.

Dr. Sensenich. Don't they?

Mr. Biemiller. They raise separate funds. I am trying to find out, are you segregating that fund?

Dr. SENSENICH. Oh, yes; the point is that that fund is entirely separate and used for that one purpose, for education. I might say, Mr. Biemiller—and I wasn't attempting to be facetious in that matter—our classification was changed some years ago from an educational institution to a business league. There are a number of other organizations in the business league.

Mr. BIEMILLER. The reason I raise this, frankly, I am not thinking just of the AMA.

Dr. SENSENICH. I understand.

Mr. BIEMILLER. But at the moment the Bureau of Internal Revenue is canceling a lot of income-tax exemptions that have existed heretofore. I know they are going over the whole situation. I just thought it was something to know if you were thinking about it.

Dr. SENSENICH. I was glad to discuss it and I wasn't trying to be facetious.

Mr. BIEMILLER. Just one or two other matters. As I said, there are a lot of them we could get into. But we will restrict ourselves.

On page 5 of the testimony, where you were talking about the voluntary plans, I notice you state you created the council on medical service in 1943. What historical date do you use, Doctor, for the change of the attitude of the AMA toward voluntary health insurance plans?

Dr. SENSENICH. I can't tell you a date. I was a member of the board of trustees for 10 years and I have been president-elect and president, too, and I was interested actively from 1930 on. I can't tell you. It has been discussed and as brought out here awhile ago with reference to Michigan, I remember when Michigan went into their plan up there. In fact, they employed a man who at that time was employed in our bureau of medical economics to lay their plans. Out in Washington that wasn't Blue Cross. But they had their own plans there.

When we speak of what the action of the American Medical Association has been, the American Medical Association is a very democratic institution and sections, States, having gone on and experimented in this or that, which probably could not be generally approved of, because we had insufficient information and insufficient experience. For a time there they were opposed not because, peculiarly enough, they were insurance plans. Nobody opposed insurance. But it was because a rule of our ethics is against the solicitation of business. When they set up a local organization to sell insurance, someone solicited the insurance, and that was the reason for objection. There was no objection otherwise. We have gone on with voluntary plans throughout the years.

Mr. BIEMILLER. Except that as late as 1938 your bureau of medical economics said voluntary plans couldn't possibly function and if you were going to have any kind of medical-care insurance, it had to be compulsory to function efficiently. I can show you that quote any time you want to see it from your own publication.

Dr. SENSENICH. That may be true. The bureau of medical economics is a very effective and very helpful bureau, but sometimes someone in the bureau says something who probably is not qualified to say it and after all the house of delegates fixes the policy.

Mr. BIEMILLER. It was said in 1934 at the same time you were opposing Blue Cross, and it was repeated in 1938. Likewise, as you well know, in 1932 the Journal took out after the very mild recommendations for voluntary health insurance of the Wilbur committee, the Committee on the Costs of Medical Care, and blasted them as "communism and socialism incitement to revolution." This has been a rather curious transition. The AMA has been throwing these phrases around rather freely over a period of some 16 or 17 years. First you threw them at the voluntary plans. Now you throw them at the compulsory plans.

In 1934 and 1938 you said voluntary plans wouldn't work, that if you did anything it had to be compulsory.

Dr. Sensenich. That was the expression of whoever was responsible for the bureau and did not fix the policy of the association.

Mr. Biemiller. Does this mean that you are going to do anything about helping take off the statutes of some 22 States the laws that your State societies have passed saying that you cannot have voluntary plans unless they have the approval of the State medical society?

Dr. Sensenich. That is purely a State matter. We have nothing to do with that. The American Medical Association never asked for that. After all, it is a matter of what happens in the various States. Personally I think it is bad business and I should not have asked for it.

Mr. Biemiller. I am happy to say that in my own State the law has been wiped out and changed. That was done in 1947.

Over in Mr. O'Hara's State, in Minnesota, they are still fighting. They won't let cooperative health groups get under way over there without the approval of the society. I think it is a terribly bad situation.

Dr. Sensenich. Will you pardon my commenting further, Mr. Biemiller, that in your last sentence there you injected a thought which wasn't in the original thinking and that was the matter of cooperatives. There might be some little argument about cooperatives as aginst other kinds of voluntary plans.

Mr. O'Hara. Will my colleague yield inasmuch as the fair name of Minnesota has been mentioned?

Mr. Biemiller. I will gladly yield.

Mr. O'Hara. Have you checked up on the last session of the legislature?

Mr. Biemiller. I have not checked the '49 session, but at the '47 session the repealer was licked. I know that. Was it passed in this session?

Mr. O'Hara. I don't know.

Mr. Biemiller. I don't think it was.

One other point that I just like to comment on briefly before yielding on my time here. I am just a little bit puzzled at another phase of your testimony, Doctor. It is comparable to the kind of statements that other officials make. You are taking great pride and justifiable pride, and I take as much pride in that as you do, that over the period of the last forty-odd years the health of the United States has made tremendous strides. The Lord knows we are all thankful for that and we hope we will make more strides.

Dr. Sensenich. That is right.

Mr. Biemiller. But the inference has always been that this is a job that has been done almost single handed by the private practicing physician, whereas it is only in the last forty-odd years that we have had any public-health program worth talking about, and I think you know as well as I do that the record shows that the AMA hasn't always been too enthusiastic in pushing the development of public-health work. You are getting a lot better on that today than you used to be. I want to give you credit for that. Particularly I want to point out that the really intensive work in the field of public health started from the time that you point out there in one of your statements about child and maternal mortality rates, in 1933, with the advent of the New Deal, and since then there has been more and more Government money spent on this question.

I am sure that you didn't mean to infer that the private practice physician all by himself has been responsible. It has been the expenditure of Government funds, the development of public-health work, and the fine research work that has been done.

On that score, I think you undoubtedly know better than I that most of the great advances in medical science have not come from any work on the part of the private practicing physician. The Lord knows he is too busy to be doing that. Most of our great advances in medical science have come from people working either under endowed foundations or in public health work or in the universities.

Mr. O'Hara. Will the gentleman yield? Has the gentleman ever heard of Doctors Will and Charlie Mayo?

Dr. Sensenich. I wonder. May I answer now?

Mr. Biemiller. All right, sir .

Dr. Sensenich. Does the Public Health Service treat pneumonias?

Mr. Biemiller. No.

Dr. Sensenich. Of course they don't. Do they treat patients at all? How far would the Public Health Service get in any State in the Union if it were not for the full cooperation and support of the medical profession? If I may finish, please.

Mr. Biemiller. Surely.

Dr. Sensenich. I have no argument as to the matter of research. Research isn't done by the general practitioner usually. On the other hand, I might say you might be astonished, Congressman, if I were to tell you how some of the things that have been outstanding have been developed by men who were not on the research staffs of hospitals.

Mr. Biemiller. I would like to have it for the record.

Dr. Sensenich. I will give it to you. That is true of Fleming, with penicillin, and various other things. But let's go a bit further. I understand before this committee there was some reference to the 12 points and our 10 points and saying the American Medical Association should not take credit for that and that those things, many of them, are now in process of being done and many of them have been accomplished and so on.

That bears out exactly what I would like to say, that the American Medical Association does not say that these 10 or 12 points are new. Many of them we have been fighting on and fighting for a long period of years. They have been accomplished and the laws in your States that have made it possible to do the things that you do have had the support of your States medical associations and your medical practitioners in the community, or they never would have happened. The Public Health Service until the establishment of Bethesda did no research work that amounted to anything, and that is due to the appropriations from here. There could be some question—I have no quarrel with Bethesda. I have been out there and it is a magnificent institution, but there is some question whether with all the money in the world you could set up any research establishment that is going to continue and immediately get the answers to everything that we are interested in. You have to have the cooperation, the practical interest and the practical helpfulness of the practitioner who is out taking care of the sick or none of these things would be accomplished.

As to where and when we changed our minds, and the head of the department of medical economics made his comments with reference to insurance plans, Mr. Biemiller, is not very exciting to me, because thank God if they were wrong that they did change his mind. What we are trying to do is to do that which is best for the whole medical service for every patient.

Mr. Biemiller. But you base a lot of your argument, and frankly I think it is a facetious one and I will come to that, on the theory that Government intervention in health is a bad thing, and yet here Government has been intervening and unquestionably it has been responsible for great advances in preventive medicine, as your own testimony shows.

Dr. Sensenich. How much has the Government done that the medical profession hasn't asked for? Let's be direct in that.

Mr. Biemiller. I will be glad to have the record filled up with a long record on that. For example, there are many cases as you know where State societies fought workmen's compensation.

Dr. Sensenich. Workmen's compensation?

Mr. Biemiller. Fought the enactment of workmen's compensation laws. I will give you the record on that right now.

Dr. Sensenich. That has nothing to do with health.

Mr. Biemiller. It has a lot to do, though, with the whole question of the care of injured. If you want to come back to public health, I am going to document for the record cases where public health measures have been fought by the American Medical Association. I will have it in the record before we get through with this hearing.

Dr. Sensenich. Very well. I would be glad to know what those were. We have a very close relationship with industry and with labor, and we have done everything we could to improve the hygiene in industry and have supported all the measures that have had to do with the improvement of health in industry. We have had no quarrel with compensation, but compensation was a matter of the financial side between the employee and the law and the employer, and had nothing to do with the quality of medical service that the individual got.

Mr. Biemiller. I yield for the moment.

Mr. Priest. Mr. Bennett?

Mr. Bennett. Doctor, I would like to have you elaborate a little bit more on how you feel the application of this bill, if it became law, would affect the quality of medical service as rendered by the individual physician to his patient.

You talked about your objections to the compulsory part of it, compulsory taxation and compulsory applicability of the provisions. I do know you are absolutely opposed to that. I know also you are opposed to the bill because of the bill's effect on the quality of medicine. I would like to know what your objections are.

Dr. Sensenich. You say the practice of medicine or upon the quality of medicine?

Mr. Bennett. On both. First on quality.

Dr. Sensenich. The practice of medicine, of course, might be something that pertains to the conditions under which the individual physician did his work. I am talking about the quality of medical service, and I did refer to that, but I am glad to go a bit further on it.

As a matter of fact, you know how it is done usually. The individual is made responsible for a certain number of patients. More often, with the exception for instance in very few countries, it is not on a per service basis, which means that the individual for a given—we will take the English pattern, for instance; the individual has a certain number of people on his panel, and he receives a certain amount of money from each one. That then is his gross income. That is his gross income, and from that those people who are enumerated on that list, which may be a thousand or more, can demand of him all the medical care they wish. There is no way in the world that he can limit it. He can't refuse to take care of them. That number of individuals, it costs nothing, just as it has recently here with all the odds and ends under the new law. If it costs nothing, then he is concerned with things of little or no consesuence. We have an increasing number of nervous patients and people who have not anything much the matter with them except that they are unhappy or upset or under stress from something entirely nonmedical in character. Those people can go in and demand time. The consequence is that, if he is going to take care of them as he has contracted to do, then they demand so much time that he can't give any of them the time that they ought to have for consideration and examination and so on. That is the practical thing.

The second thing is that it is involved in a tremendous number of forms, reports. You know what Government is like in the number of carbons, and so on. Some of these men practically work all night keeping their reports in line.

Then, beyond that, there comes the matter of prescriptions, again surrounded by a lot of regulations as to what they can give you and how much they can give. One must be factual about it. Sometimes the patients are a bit inclined to ask for things which are irregular. That is not patients alone. If you recall when you were giving away fruit here some years ago, they used to take the fruit and some of the men went to the corner grocery and traded it for tobacco, things of that kind.

You have all of the things that the human ire or uncertainty or unhappiness can reflect into the pattern. But last of all is the fact that, not only is the incentive gone, but the quality of care depreciates because the individual has too many people to see in a given time, and, lastly, the conditions in the practice of medicine become so unattractive and so unrewarding to the fellow who really is a superior type that he doesn't study medicine. So you don't have that.

I say to you, if I may just finish this up, let's come to the quality of medicine, of medical care. In one of the countries of Europe today, talking about medical men, any man can enter a medical course without any selection. We feel here that the man should be qualified. When you are ill and call a physician in the middle of the night, you are dependent upon his judgment and his honesty and his earnestness to do the thing for you. For that reason, the men are more or less carefully selected in the schools as a man who is stable mentally and is the type of man who should be in medicine. They are accepted in the medical schools without an examination; they have no examination during the first 2 years of medical school, none whatever to determine what the quality of work is that they are doing or how much they are learning. At the end of 2 years they are given a very perfunctory kind of once-over which doesn't amount to much, if anything. They have no examination, and at the end of 4 years they are qualified to practice medicine without ever having an examination.

The only thing in the world that determines whether they practice medicine or not is, if the local political authority decides that there are enough physicians in one town and they should not accept another, he can't get a license to practice there; and, on the other hand, if there is room or he happens to know the district man well enough, then he gets a license.

Those are the things that grow into this system.

Mr. BENNETT. Those things you are talking about being admitted to practice, those aren't in this bill; are they?

Dr. SENSENICH. No; they are not in the bill, but I am telling you when the field becomes unattractive then the tendency is to lessen standards and requirements.

Mr. BENNETT. How do you mean that a doctor's income is limited? You said there was no incentive, and his income is limited.

Dr. SENSENICH. It depends on whether he is on the panel system.

Mr. BENNETT. I mean under this bill.

Dr. SENSENICH. I am sorry I am not familiar with that. This I think permits or is said to permit a locally designated regional board to determine whether it shall be on a panel system or on a per service basis. Isn't that right?

Mr. BENNETT. On a fee basis.

Dr. SENSENICH. Yes. In other words, the authority frequently decides upon the panel basis, and I say the authority, not necessarily the physician, because that is an outside group. On the panel system, then, the individual is paid so much per person on his panel. If he has a thousand and he gets the equivalent of $4 a year from each one, then he would receive $4,000, no matter how much or how little he does.

Mr. BENNETT. He would have a guaranteed minimum annual salary.

Dr. SENSENICH. He is guaranteed that in proportion to the number of people who ask to sign up on his panel. The Government only restricts the number for whom he may assume responsibility.

Mr. BENNETT. Mr. Kingsley testified this morning that under his bill, either at the Federal level or the State level, some Government board would determine the amount of money that would be spent for medical care and services in any one community.

Dr. SENSENICH. That is right.

Mr. BENNETT. Is that what you are referring to?

Dr. SENSENICH. Yes.

Mr. BENNETT. You say the doctor's income would necessarily be limited by that procedure.

Dr. SENSENICH. That is right. One of the things that troubles them in Europe at the present time is that in a good many areas, even though they are supposed to receive a certain amount of money, the amount of money appropriated is not sufficient to carry out according to the pattern; and, therefore, they get half that amount. The physician can't help himself in that, no matter how good work he does.

Mr. Bennett. What about specialists under this bill?

Dr. Sensenich. That I can't answer. I am sorry. I didn't think we were going to take this up by special titles. I don't know what the provision there is made for specialists.

Mr. Bennett. You know a provision is made for special fees. Does the specialist get more fee for the same type of work than the general practitioner, for example?

Dr. Sensenich. In a general way in practice, the specialist does get a larger fee, but he sees fewer patients, and it is assumed—in fact, he must in this country qualify as a specialist. He must have had special work, which means that he has been to considerably more expense in his preparation and that he holds himself only to that one field.

Mr. Bennett. I was wondering what would happen in a good many rural communities of the country. The general practitioner does routine operations, like tonsillectomies, appendectomies, and so forth. You put this kind of law into effect so the citizen can go to any type of doctor he wants to; I assume that includes the specialist. Do you think this might have the effect of piling all the work on one man and taking it away from others?

Dr. Sensenich. That is what it did under the Children's Bureau during the time when we were taking care of the mothers of men in the service. Despite all the effort to hold them in their normal communities, there were a great many who promptly went into the larger centers and selected some specialist for their medical care. I am not complaining about that. That was all within the law, and there was no reason why they should not do as they wish to do, but that is the way it worked.

It might remove a lot of that work but still leave the local man to do the other things. Peculiarly, one man in conversation down here several years ago was greatly distressed because his sister had a boy who had some particular eye condition and they had to transport him a long distance to get him to a specialist, and he thought that should not be true. So we talked about it and I said, "How large is this town." It so happened that the town was in the Southwestern States, and the population was very scattered. The place was a very small town.

I said, "After all, if you had an eye man in that community capable of doing that kind of work, he probably would see about two or three or four or five of that kind of cases in a year. He would be useless."

Mr. Bennett. That is all.

Mr. Priest. Mr. Wilson.

Mr. Wilson. Dr. Sensenich, we are trying to deal here with a subject that eventually will touch the life of every American citizen. You have presented a 12-point program here in the over-all picture. No. 3 of that relates to the general subject of voluntary insurance. While this discussion has been going on, I have had an opportunity to look at a little bit of your brochure. Is this Blue Cross-Blue Shield hospital and physician service the answer of the American Medical Association to the so-called onslaught or threat of so-called socialized medicine?

Dr. Sensenich. No. That is voluntary insurance the same as the other insurance companies. We are not selecting anyone and saying that is the method.

Mr. Wilson. Does your association of doctors embrace that now and believe in it thoroughly, or is it only half-hearted?

Dr. Sensenich. You mean the Blue Cross and other plans?

Mr. Wilson. Yes, sir.

Dr. Sensenich. We have approved of them for years. Mr. Biemiller raised the point awhile ago as to when. I wouldn't argue about that, because I don't recall exactly when it was. But we do approve of all voluntary-insurance plans that are actuarily sound, which means that there are also the private and other insurance companies.

Mr. Wilson. It was passive resistance then; and, if it did exist in the past, it has diminished. Is that correct?

Dr. Sensenich. Mr. Wilson, I would have to correct that. There has been no resistance except as it was being explored. Let us have this in mind, sir; that at that time the commercial companies or any of the other insurance companies did not write that kind of insurance, and this was exploratory; and, of course, no one could go out and advance and prove and support to the public plans that were untried. These areas were simulated and encouraged to continue their studies, which they have now done, and it is found to be practicable.

Mr. Wilson. I hardly know as to very many of the members of this committee or many of the Members of this Congress, but my guess is that there are a great many, including myself, who do now hold and for several years have held membership in voluntary so-called physicians service and the Blue Cross.

Dr. Sensenich. That is right.

Mr. Wilson. Therefore, we are not only individually interested, but we are interested in the advancement and welfare of our Nation.

Dr. Sensenich. That is right.

Mr. Wilson. In the brochure I see that the State you were referring to a while ago, Oregon, originated in 1930.

Dr. Sensenich. Washington.

Mr. Wilson. Washington in 1943, the State of Michigan in 1939.

Dr. Sensenich. Well, I would not give those years because I do not know.

Mr. Wilson. I want to explore this same subject with you a little longer. I heard a statement this morning by a practicing physician that did shock me. I am reading it now and he said:

> Next one hears a great deal about the importance of there being no interference between the physician and the patient in the guaranty of good quality medical care advanced by the supporters of voluntary health-insurance plans.

Now notice particularly the next sentence:

> Yet it is generally admitted that the biggest barrier between the patient and the conscientious physician is the dollar.

Let me hear you comment on that?

Dr. Sensenich. I would say that is absolutely unjustified; and I do not care who made it; it was made for a purpose and there is no background for it. I do not say that every medical man is exactly what he ought to be any more than I would say for any other field of activity, and I would except none.

But, on the other hand, to make that charge that everything that medicine does, against compulsory insurance or otherwise, is based on a purely financial basis, is unjustified; and again, sir, I do not care who said it.

Again, sir, may I just explain one other thing briefly, and that is this: We are talking about rural areas here, or were a moment ago. We are exploring insurance with reference to the rural inhabitant, the fellow out on the farm. They have not been able to cover him with the kind of insurance that they get in the cities, and the reason has been that it is a matter of selection. The point of the matter is that the man is employed in industry and he is going about his work day by day, and it is assumed that he is reasonably well and he is a good risk.

They save the cost of what the insurance companies call their acquirement cost, and they assume that these men are therefore all right. With the farmer or the individual outside, not in a group, it is not possible to do that, and now we are exploring that very thing to see what their experience is, to see whether the Blue Cross and all these other plans cannot extend their activities to the individual out in the rural areas. That is why the matter of voluntary insurance has been a little slow in development.

Mr. Wilson. Referring specifically to point No. 3 in your 12-point program:

> Further development and wider coverage by voluntary hospital and medical-care plans to meet the costs of illness with extension as rapidly as possible into rural areas. Aid through the State to the indigent and medically indigent by the utilization of hospital and medical-care plans and local administration and local determination of needs.

Dr. Sensenich. That is right.

Mr. Wilson. Do you folks agree, your association, that something needs to be done?

Dr. Sensenich. That is what we are trying to do, sir.

When you have 80,000,000 people covered one way or another, that is a pretty good showing.

Mr. Wilson. When—and I am emphasizing the word "when"—do you believe something needs to be done?

Dr. Sensenich. We are doing it all of the time. We will have that in operation in a much better degree in a given time than would be possible under this kind of legislation.

Mr. Wilson. Let me ask you this rather open and large question. What—and I emphasize the word "what"—do you propose to do to further develop and give wider coverage to help bring more medical aid to a greater number of people?

Dr. Sensenich. Mr. Wilson, that is just what I said a moment ago that we are experimenting with what can be done with a detached individual not in a group. That is the important thing because the minute experience on that justifies it, we can take in millions of people that at the present time are not eligible to these various group insurances. Now beyond that, of course, is the matter of setting up and we have supported that legislation, the health centers, the public health centers, health education, the regional hospitals. Those things are not all answered by one sentence or one piece of legislation, they are the things that we, you gentlemen, you have to do with legislation, and those of us in medicine who know the needs have to work on together, and we are trying to advise you the best we can.

Mr. WILSON. You have considerable experience already accumulated?

Dr. SENSENICH. Oh yes; as evidenced by the enormous number of people. In some of the States, some of the Western States; some of them have been doing that out in your State, Mr. O'Hara, I might add.

Mr. WILSON. What is your explanation of the difference here, as has been referred to this morning and use this afternoon, calling people indigent or medically indigent? What is the difference?

Dr. SENSENICH. I do not know how it is in your State, Mr. Wilson. In my own State we have certain officers who are responsible to provide medical service for those people unable to care for themselves. Now the individual may own a home or he may have been able to get along and had some income along the line but he is medically indigent. Now that man should have provided for him the best medical services and he is medically indigent, although he may not be fully indigent otherwise.

Mr. PRIEST. Mr. Sadowski? I believe you indicated you had one more question?

Mr. SADOWSKI. Yes; I have one more question.

Doctor, you stated that you are opposed to title VII of the bill?

Dr. SENSENICH. May I locate title VII?

Mr. SADOWSKI. This is it. What if we come to another period of unemployment and depression and we are already beginning to feel a little of this unemployment in Detroit, maybe partly as a result of the strikes but also because of general conditions, especially a lot of the smaller plants have been lying off many men. When we get to a position where the situation get to be quite serious and a good number of people will be out of employment and have no money to pay for these medical services and hospitalization, would you still even in a condition of that kind, oppose Government aid and assistance or Government payment of premiums for insurance? Should Government step in, in any way whatsoever to take care of these medical bills, hospitalization bills?

Dr. SENSENICH. We have always been out, sir, to have, and I am sure that is in my statement there to the effect that we feel that the individual should be taken care of at local community expense and if they are not able to do it.

Mr. SADOWSKI. My dear Doctor, do you realize that during the last depression the city of Detroit could not take care of anything? The city was completely broke and busted. We issued script to pay off our firemen and policemen and teachers, coupons which were redeemable in city taxes. You could buy that scrip for 50 cents on the dollar and it had practically no value.

So, the city of Detroit may be in the same position if we hit another depression. Our city treasury is rather limited and we could not depend upon local authority to assume this burden.

Suppose we strike another period of depression and unemployment like that, is the only solution the one that we had the last time and these people would go without medical attention, without dental care, or have the doctor holding the bag? I mean where the doctor winds up with thousands of dollars on his books which he can never collect and the hospitals are of course reluctant to take these patients and the city-owned hospitals are overworked and overcrowded. Of course the private hospitals are not interested in taking these people that have no money.

Dr. Sensenich. Congressman, it might interest you to know that during that time I was in Detroit. I had the results of your study of the situation. I know that your people did not suffer in the main because they could not have physicians and actually those who were on relief got a little more medical care than a lot of other people did.

Furthermore, I was in Washington many times at the time Harry Hopkins was in charge and then later the other man whose name I cannot recall at the moment. After all, the fact that you put up a compulsory insurance fund is not going to put another dollar in that fellow's pocket. Somebody up there would have to do it or the Federal Government would have to put up money for it. After all, there is nothing occult or mystic about insurance.

Mr. Sadowski. You are exactly right and that is what I wanted to point out. The doctor who received a $2 bill from the county or the city for a patient, that $2 came from the Federal Treasury and was given to the counties and States to take care of that situation.

Dr. Sensenich. That is right and it may be necessary to do it again because the unemployed can do nothing for himself.

Mr. Sadowski. Do you think that this is the solution for this problem?

Dr. Sensenich. That is a better solution than what you have here by forcing a compulsory program on your people. I know about your people there, I have those records. I am not quarreling with the idea and above all things I want the individual to take care of himself.

On the other hand, if he cannot and the community cannot, then the Nation should. You will find that the doctors were right alongside of you working to see that those people got medical care at that time and they would do it again. Some of them were never paid, and that is all right too. But, after all this is not the answer to that need. Furthermore, and I want to mention another thing because someone has mentioned that means test, the means test is all through the picture. It is in our Federal security and income tax and everywhere. Even your individual in Federal security today, if he does not pay up to 10 years and become definitely and permanently fixed, and even if he does and he gets to 65 years old and earns more than 50 cents a day, there is a problem.

Mr. Sadowski. The people 65 years old, I am interested in that phase also.

Dr. Sensenich. That is right.

Mr. Sadowski. We give him a little pension over there in our State, probably about $40 a month.

Dr. Sensenich. If they do not earn over 50 cents a day.

Mr. Sadowski. Probably.

Dr. Sensenich. That is correct.

Mr. Sadowski. It is around $40 a month. Now most of those people are sickly and they do need medical attention.

Dr. Sensenich. That is right.

Mr. Sadowski. They need hospitalization.

Dr. Sensenich. That is right.

Mr. Sadowski. What about them? What kind of program have you to offer those people?

Dr. Sensenich. The American Medical Association, the American Public Health Association, and I have forgotten the other, are making a study of that aged group. They need care, there is not any question about it, but they should not have it in an expensive hospital. They do not need that; more often what they need is custodial care. We need special institutions for that care. We have been doing that job, making studies in Chicago and other places and now we are financing the study with the idea of developing the kind of institutions that those people need and quite probably in the end your State or the Federal Government will build those institutions but that has nothing to do with compulsory medical care.

Mr. Sadowski. Well, the institution is not the answer. That is part of the answer, but not the whole answer. There are so many people that do have a little home, or they may be a father and/or a mother living with their children, but when they are ailing and they need this assistance, I know they come to me, "Look Congressman, I am only getting a little pension here, and I need this care. My doctor bills are so and so and my medical bills take up so much of this money and I have hardly anything left." In many instances they have nothing left. It is quite a problem and just saying, "Well, I will put you in an institution," that is not the answer either. A lot of these people are not ready to go to an institution but they do want a doctor to take care of them where they can stay at home and pay a call to the home.

Dr. Sensenich. That is what we are struggling with, sir.

Mr. Sadowski. But you do not have the answer for that today?

Dr. Sensenich. No; we do not have the answer, but this is not the answer either, I am sorry to say, sir.

Mr. Priest. Any other questions?

Thank you, Doctor.

Dr. Sensenich. Thank you very much.

Mr. Priest. May the Chair state at this time that it will be necessary for the subcommittee to adjourn at 4:30 this afternoon which leaves us 30 minutes. We had hope to hear Dr. Goin, from the American Medical Association, Dr. Flagstad, from the American Dental Association, Dr. O'Shea, of the American Optometric Association, former Congressman Thomas R. Amile, of Wisconsin, Dr. William Ezell, of the American Optometric Foundation, and Dr. Griffith, of the National Economic Council.

If we are to hear all these witnesses we will have to proceed rather expeditiously.

The Chair desires to state again that the hearings on the 7th and 8th of June apparently will have to be dedicated also to general statements on the legislation, at least one of those days, because we have not been able to accommodate all of the witnesses during these 3 days with general statements.

Next we have Dr. Goin. I am informed that he is at the moment before a Senate committee.

Mr. O'Hara. I would ask unanimous consent of the committee that Dr. Goin's statement be inserted in the record at this point and that he be allowed the privilege of appearing later for questioning.

Mr. Priest. Without objection, that will be done.

(The statement and supplemental statement of Dr. Goin are as follows:)

Statement of Lowell S. Goin, M. D., Los Angeles, Calif.

I am Lowell S. Goin, M. D., of Los Angeles, Calif. I am a practicing physician and I happen to be president of California Physicians' Service; the voluntary health-care plan of California. I had as well say at once that I am in complete opposition to this legislation. I oppose it as a physician because I am persuaded that its enactment would result in a great and continuing decrease in the quality of medical care available to our people. I oppose it as an American because I am persuaded that this type of legislation is one of the final steps on the road to state socialism. In this opposition, I am confident that I am supported by the overwhelming majority of American physicians.

Specifically, my opposition is based upon five premises which I propose to state briefly, thereafter developing each one.

1. The assumption that the health of the American people is bad is a false assumption.

2. The assumption that the enactment of compulsory sickness tax legislation would be in the interest of the public health is totally unfounded.

3. Medical care is not the sole factor in the problem of health, and there are many things that Government could properly do which would benefit the health of the public far more than the proposed legislation.

4. The cost of such plans, rather lightly passed over by the President and the Social Security Administrator, are totally unpredictable and almost certain to be extremely high.

5. Voluntary health care plans, which are truly in the American tradition, are giving good medical and hospital care to our people, and must be allowed to develop unhampered by bureaucracy.

Let me now consider these points each in its turn.

1. The health of the American people is bad, perhaps, but it isn't bad just because someone in the Social Security Administration says it is. Fortunately, it is a matter which may be investigated, and in which conclusions can be based on known facts rather than on emotional statements. Consider then, if you please, that the life expectancy at birth is steadily increasing, being now about 65 years for a male and 69 years for a female. It is materially less in Great Britain, and was still less in prewar Germany. Both of these countries have long enjoyed the blessings of compulsory sickness insurance. The death rate from diphtheria per 100,000 of population, in the last year for which comparative figures were available, was 11.6 for Great Britain, 11.4 for Germany, but in the United States, with a benighted free enterprise system of medical care it was less than 6.0. Why? Diphtheria is both preventable and curable; why didn't the Government-operated medical systems produce a death rate lower than ours? In the public health reports for August 1946, the United States Public Health Service presents a table showing the death rate from tuberculosis in all countries. In the United States the rate was 47 per 100,000. In England and Wales it was 62. In France it was 137, and in Russia, 160. All of these except the United States have national medical care plans, but they seem to have been quite unable to equal the performance of the United States.

Some of the most lucid statements which are used to document our bad state of national health are found in Mr. Oscar Ewing's report to the President entitled "The Nation's Health." Perhaps I may be permitted to digress for a moment, and to wonder what magical powers are inherent with civil servants of the Federal Security Agency, which makes them so omniscient in the problems of medical care, and why their opinions so greatly outweigh those of the 197,000 physicians of America whose entire lives have been spent in acquiring professional training to cope with these problems and in the actual coping with them. Mr. Ewing begins with a dramatic statement; a statement made to order for breadlines: "Every year 325,000 people die whom we have the knowledge and the skills to save." Of these he says, 170,000 die of communicable disease, and that we should be able to save 120,000 of them. This last figure seems to have been chosen at random, and no documentation is offered. As is not uncommonly the case, the figures are not exactly accurate. In 1945, 177,000 people actually did die of communicable disease, but in 1947 the figure had been reduced to 137,000. That the figure of 40,000 saved by our present system of medical care does not particularly bolster the case against that system is not mentioned.

Perhaps this is purely coincidental. It is a fact that the death rate from communicable disease is the lowest in our entire history.

Mr. Ewing also says that we should be able to prevent 115,000 of the more than 600,000 annual deaths from cancer and heart disease. I am unable to ascertain the reason for the selection of the figure 115,000, and I suspect that it is a purely arbitrary selection. I don't know how many of the deaths were due to heart disease, but it is probably fair to assume that about two-thirds were. Is the implication that these people died because of lack of medical care a fair one? Of course it isn't. Actually, both heart disease and cancer are diseases of the latter decades of life. People eventually die of something, and the more people who live into these decades, the more will die of these diseases. If medical care is the problem, it is curious that the six States with the lowest death rate from heart disease were in the deep South, and that seven of the nine States with the highest rate were in New England. New England has more physicians, more hospital beds, more research centers, and more teaching institutions than the entire deep South. I repeat that it is most curious that the death rates shcould not fit the amount of medical care available.

Mr. Ewing complains of the shortage of physicians. One wonders why he believes that the enactment of a law bitterly opposed by physicians (physicians' sons are a substantial part of the annual crop of new physicians), and one which experience in other countries has shown to degrate physicians, could possibly increase the number of physicians. I predict confidently that the enactment of this legislation will decrease the number of physicians produced annually, and that it will very materially lower the quality of the young men who enter medicine.

Another ill to be cured by compulsory sickness tax legislation is the inequitable distribution of doctors. There seems to be a vague and hopeful feeling that some magic inherent in this so-called social legislation will persuade doctors to leave cities, where medical schools and libraries are located; where hospital and consultants can be found; and most of all, where man can have the society of his peers, and go to remote hamlets where none of these things are available and where he can stagnate in intellectual loneliness. Doctors, like other people, locate themselves where they think they are most likely to succeed, and where they will be happiest. Why anyone should believe that enactment of a law will change these elementals is something of a mystery, but one which would be solved promptly if a paternal government were to direct physicians in choosing their fields of activity. Any such intent would be vigorously denied, of course, but the Government of Great Britain has already assumed this right and has announced that more medical care in rural areas would be provided by paying a somewhat larger capitation fee in such areas and (n. b.) by forbidding doctors to locate in more populous zones.

2. The assumption that enactment of this legislation would be in the interest of the public health is unfounded. Fortunately for my argument (although unfortunately by other standards) we have a system of so-called compulsory health insurance in actual operation in the city of San Francisco. Set up by ordinance several years ago, it embraces more than 20,000 employees of the city and county of San Francisco. As a public duty, and as a noble experiment, the medical profession of San Francisco consented, almost to a man, to cooperate with the plan which is called "Health Service System." I see no reason to believe that a like system on a national level would function much differently than this "pilot" plan, and this is how it really works; this is what we may reasonably expect to happen once the plan begins to operate nationally. On May 28, 1947, Dr. A. S. Keenan, medical director of the Health Service Plan found it necessary to address himself to the physicians of San Francisco. He complains of overuse of the system, and urges great curtailment of the care given. The following are his own words: "People in general have more knowledge now on medical subjects. * * * It has brought about many unnecessary visits to the doctor to get treatment for trivial things. Such minor ailments could be treated as well by their home remedies as by their doctor." There, gentlemen, is a panel system in operation. The earliest, indeed the only early symptom of lung cancer is a trifling cough. Go home and take some cough medicine. The only early symptom of gastric cancer is a trifing indigestion. Take some soda. Next, the medical director complains of clinical laboratory and X-ray expense, and again I quote his words: "The people in general know little about the results that can be obtained from the help of laboratory tests or the X-ray examinations. Please, doctor, turn such requests aside. * * * It would seem that any physician,

after taking a short history of his patient's case and making a routine examination will find that he can make a diagnosis without leaning so much upon the laboratories and the X-ray departments."

Please note that early recognition of brain tumors requires laboratory study of the cerebrospinal fluid, and that early diabetes is recognized by the amount of sugar in blood. After complaining that it cost too much to hospitalize these unfortunate people whose pay checks were subject to compulsory deduction for the service, he says: "The members of the Health Service System, except in a few obscure cases, do not need any such extensive work." As is easily possible under the compulsory system, the director solves the problem neatly, thus: "Hereafter no patient, except in an emergency case, will be entitled to hospital benefits under Health Service System coverage until authorization has been given by the medical director." There you have the panel system which our planners would like to institute; there you have medical care under compulsory health insurance. Personal interviews with British physicians who have been so revolted by the system that they have actually fled to the United States to start all over again, and correspondence with others who wish that they could flee, indicates that this is a completely fair picture of so-called compulsory health insurance benefiting the health of the public. If further evidence is needed, we might let Dr. Nathan Sinai furnish it. Remember that he is an able and ardent proponent of compulsory sickness tax legislation. I quote from his book the Way of Health Insurance, pages 157, 158: "Contrary to all predictions, the most startling fact about the vital statistics of insurance countries is the steady and fairly rapid rate of increase in the number of days the average person is sick annually, and the continuously increasing duration of such sickness."

"Various studies in the United States seem to show that the average recorded sickness per individual is from 7 to 9 days per year. It is nearly twice that amount among the insured population of Great Britain and Germany and has practically doubled in both countries since the installation of insurance." To this he adds: "It seems to be a safe conclusion that insurance has certainly not reduced the amount of sickness." This surprises me, since I had naively assumed that the proponents believed that it would reduce the amount of sickness. Certainly, the words quoted comprise an excellent argument against this sort of modical care, although I doubt that Dr. Sinai meant them to be.

3. A sort of current custom is to use the terms "medical care" and "health" as if they were interchangeable—as though one were a synonym of the other. As a matter of fact, medical care is only a small part of the health problem—not even the most important part. Health consists largely in not being sick; medical care consist largely in an attempt to cure or alleviate disease. Nearly all—perhaps all—of the health legislation which has been proposed from time to time has been written by social planners, seldom, if ever, in consultation with physicians. Consequently nearly all it contains is wishful thinking and not too much reality. Too much confidence is placed in preventive medicine, too much earnest belief that periodic health examinations will prevent disease, and all the legislation evidences a complete failure to understand that preventive medicine simply has not yet attained the goals wished for. To cite a few of the problems: How shall heart disease (except that due to rheumatic fever) be prevented? What sort of health examination will be efficient in its control? How shall we prevent, or even recognize, early brain tumors? Shall everyone with a headache have encephalographic or ventriculographic studies? Shall we do gastrointestional X-ray studies on everyone with indigestion, and, if so, where shall we obtain the skilled personnel? How are bone tumors prevented, and what periodic examination makes one aware of the pneumonia of next week?

Medical care is, and will for a long time continue to be, the care of the sick and this, I repeat, is only a fraction of the health problem. Some other fractions to which Government might well turn its attention are sanitation, hygiene, health education, adequate diet, good housing, adequate clothing, working conditions and patent medicine control. And there are many others. If Government is sincerely interested in the health of the citizen, why should it not suppress patent medicine advertising? Why should it not regulate cults and require that all who wish to practice the healing arts pass the same tests? Why should it not control radio publicity of nostrums, vitamins, and the like? This current legislation is attacking only a small segment of the health problem, and even if it were to accomplish all that its proponents claim, it still would not solve our health problems.

4. I shall refrain from elaborating in my statement that the costs of the proposed program are unpredictable and are likely to be extremely high. I am

sure that there have been or will be witnesses much more able to cope with these problems than I, and I shall leave to them the discussion of the financial problems.

5. Voluntary health care plans have made a truly phenomenal growth. Thirty-two million people have Blue Cross insurance. Eleven million have medical care plan insurance. Twenty million more are covered by commercial carriers, and competition by Blue Shield plans has made them offer good comprehensive contracts. If permitted to do so, voluntary plans will ultimately cover a great majority of the American people. If there are rugged individualists who decline thus to protect themselves, must we compel them to do so? I seriously doubt if it is true that half the families in the United States are unable to pay for voluntary coverage. I feel sure that nearly all families can afford it if they are willing to assign a sufficiently high priority to medical care. In 1947 the American people spent $3,000,000,000 for medical and hospital care, including drugs and the services of irregular practitioners. They also spent 3.9 billions for tobacco, 9.4 billions for movies and recreation, and 9.6 billions for alcoholic beverages. Is it seriously argued that this budget could not be rearranged? And, moreover, aren't the same families going to pay for national compulsory sickness tax service? Will it be less painful to have the cost deducted from the pay check? Will the small self-employed person who wishes neither voluntary nor compulsory plan be happier when he is taxed for one?

Voluntary health plans will, if given the opportunity, do the job, and do it better than Government-controlled plans can do. These plans, which already include a very large number of persons, are in accord with our traditional emphasis on personal responsibility, prudence, foresight, and thrift. They have an American dignity which is lacking in the regimentation of compulsory health insurance. They can be and are more economically administered, they can and do give better medical care, and they will be and are supported by thousands of physicians who are bitterly and unalterably opposed to Government-controlled medicine. In California we have made a good start. Our California Physicians' Service offers medical care at modest costs. Nearly 800,000 of our people have availed themselves of it, and appear to be quite satisfied with it. The Farm Security Administration had a medical-care program for the rural indigent. California Physicians' Service took it over and gave better medical care for less money and to the satisfaction of those giving and receiving the care. California Physicians' Service has a contract with the State Grange providing medical care for nearly 100,000 farm people. These activities, which are duplicated in most of our States, are indications of how voluntary plans can meet the challenge, how they are meeting it, and how they will continue to do so with a steady and healthy growth if they are not crushed by the monster of bureaucratic control.

May 24, 1949.

Statement by Dr. Lowell S. Goin, of Los Angeles, Relative to the National Education Campaign of the American Medical Association

During recent weeks and months the American medical profession has been subjected to maliciously unfair abuse from certain advocates of compulsory health insurance, some of whom are officeholders in the Federal Government. Through vicious innuendo, false implication and outright distortion of fact, deliberate attempts have been made to undermine public confidence in the Nation's doctors, and to make it appear that the American Medical Association is engaged in devious, unethical tactics in its opposition to national compulsory health insurance.

Very few Members of Congress have been a party to this attempted smear. However, you gentlemen probably have heard or read some of the false charges. I believe that you know in your hearts that American doctors, by their very nature and training, would not take part in the questionable activities which have been implied in this scurrilous propaganda. Nevertheless, we need to clear the record with respect to these trumped-up charges.

The American Medical Association—openly, frankly, and honestly—is engaged in a national education campaign to give the people the facts about compulsory health insurance and the facts about voluntary health insurance. We frankly oppose the first and we enthusiastically favor the second. We hope and believe that the American people, given the facts, will agree with us.

In the best American tradition we are taking our case before the forum of public opinion. We are asking for a vote of confidence in the American medical profession and in the American medical system, the finest in the world. We are doing exactly what you gentlemen do at election time. We are using the same avenues of approach—the press, the radio, the speaking platform, pamphlets and leaflets, and all other accepted, ethical means of submitting our case to the people.

The Committee for the Nation's Health, the Physicians Forum, and other groups favoring compulsory health insurance, are conducting a constant propaganda in behalf of it. For 10 years or more, the Federal Security Agency and other Government agencies have been spending unauthorized tax funds to thump the drum for socialized medicine. Now, however, when the American Medical Association finally strikes back at the distorted propaganda of the socializers and Government pay rollers, we suddenly hear unfounded and intemperate charges that the American Medical Association is invading Washington with a high-powered lobby and a huge slush fund.

These charges are absolutely false, and those who have been making them know they are false. As you gentlemen undoubtedly know, the Washington office of the American Medical Association is one of the smallest, most conservative legislative offices maintained by any of the national associations in the capital. It is staffed by men of unquestioned integrity, who are highly respected in Washington. Whitaker & Baxter, the public relations organization which is directing our national education campaign, has only one representative in Washington, and he is a press representative, not a legislative lobbyist.

The American Medical Association, in its national education campaign, is carrying its case directly to the American people in a grass roots crusade which we hope will reach every citizen in this country. By so doing, we doctors are simply exercising one of the greatest rights which Americans have as a free people—the right of petition as set forth in the United States Constitution. We are exercising that right not simply to protect the medical profession from degradation, but to protect the health of the Nation.

The people have a right to know that Government-controlled medicine means inferior medical care doled out according to bureaucratic regulations and rule books, ever-increasing pay-roll taxes, invasion of privacy and freedom of action, and destruction of the voluntary health insurance plans which provide good medical care at a lower cost than Government ever could provide it.

In the final analysis, the American people, through their representatives here in Congress, will decide this issue. The objective of the American Medical Association national education campaign is to get the facts to the people. We want them to make their opinions known to their United States Senators and Representatives. We believe you want it that way.

If that is lobbying, it is lobbying in the finest American tradition, and every doctor is proud of his part in the program.

There is nothing secret or devious about this campaign. It is an open and aboveboard public campaign on a vital public issue. The plan of campaign explaining the program has been distributed by the thousands throughout the country—not only to doctors and medical societies but also to a wide variety of interested parties, including newspapermen and magazine writers. For your information, I am filing a copy of the plan of campaign with your committee. Nearly 14,000 copies of this have been distributed all over the United States. There is nothing in our program which is secret—and you may have copies of any material we are issuing simply by requesting it.

Yet, at least one radio commentator and one Congressman, in recent public utterances, have quoted from these widely-publicized materials, attempting to give the impression that they were revealing "shocking" information from "secret" documents. Apparently depending on the same unreliable source for their information, both men referred to the fact that American doctors intended to present their case in newspapers and magazines, and that doctors were urged to write letters to any Senators or Representatives who were their personal patients. These alleged "revelations," gentlemen, are nothing short of ridiculous. Since when is it a crime to submit material to newspapers and magazines? And since when are doctors deprived of the ordinary right of any citizen to write to the men who represent them in Washington?

If there is any need for a congressional investigation of lobbying, it is for an investigation of the Government lobby which has forced the American medical profession to strike back in defense of its good name. The Harness committee reported to the House of Representatives in 1947 that at least six agencies in the executive branch of the Federal Government were using Government funds in an improper manner for propaganda activities supporting compulsory health insurance. The Federal Security Agency alone has become a tremendous propaganda agency for Government medicine.

It seems very strange to me that when I appear anywhere to speak on this subject, some representative of the Federal Security Agency often shows up in the same town, speaking in favor of Government medicine. Who pays for this? Has Congress authorized the use of Federal funds for these propaganda lecture tours? Is the Federal Security Agency usurping the rights of Congress, the regularly established legislative branch of the Government?

As I mentioned a moment ago, Government agencies lobbying for compulsory health insurance—some of them for 10 years or more—have forced the American Medical Association to embark on its national education campaign. Although the great bulk of these campaign activities and expenditures do not constitute lobbying under the terms of the Federal Lobbying Act, Public Law 601 by the Seventy-ninth Congress, in the opinion of our legal counsel, the campaign directors have registered according to the letter of that law. A report of expenditures for the first quarter of 1949 already has been filed, listing separately every item over $10. We invite the closest possible scrutiny of all reports and records.

More than half of the time, effort and money in this campaign will be used in affirmative, positive action, designed to aid in the development of the voluntary prepaid health systems. American medicine is far more concerned with solving a problem than with simply defeating a bill for compulsory health insurance. The ultimate, long-range objective of this campaign is to make the American people more and more health insurance conscious. We want them to know that sound protection against the costs of illness is available under existing voluntary health insurance plans, at reasonable rates far below the inevitable high cost of a compulsory, tax-supported program. We want the people to know that the many different hospital, surgical and medical insurance plans are working constantly to extend their benefits. Already there is a tremendous demand in this country for voluntary health insurance. The greater that demand can be made, the quicker this problem will be resolved. The great need in America is not for compulsion but for a general realization by the people that health protection is an essential item which should be given its proper priority in the family budget, and which can be so budgeted without undue financial burden.

I think I am correct in saying that several members of this committee feel the same way. A number of you gentlemen have shown a definite interest in the great progress of voluntary health insurance, and you are sponsoring legislation embodying principles which we fervently support. We think you are on the right track to an American solution of this problem.

The American Medical Association National Education Campaign, by alerting the people to the wisdom and necessity of handling this problem themselves, is making a contribution toward the further improvement of our national health. We believe it also is performing a service of value to Congress, by making it unnecessary for you to levy new pay-roll taxes and launch this Nation into a dangerous experiment in Government medicine. Such an adventure would impair or destroy not only the American medical system but also our national financial stability. There are other, more sensible ways to solve our problems in medical economics.

Let's stop the small-boy name-calling. Let's settle this issue like adult Americans, using the best medical and economic tools that exist on the face of this earth.

May 25, 1949.

Statement of Representative Andrew J. Biemiller of Wisconsin

Mr. Chairman, I am sorry Dr. Goin did not appear in person so that we could question him about some of the statements he made—particularly, those defending the tactics of the American Medical Association in its propaganda and lobby campaign against the President's health insurance program.

Dr. Goin asserts the AMA is "openly, frankly, and honestly" carrying on a "national education campaign" to give the people the facts about compulsory health insurance and the facts about voluntary health insurance." He adds that there is "nothing secret or devious about this campaign," and as evidence of it submits a "copy of the plan of campaign" which he says is being distributed all over the country.

I want to point out that this "plan of campaign" which was presented to the committee is in itself a bit of window dressing by the AMA. It is a carefully edited, whitewashed version of the real plan of campaign which Representative Dingell submitted to the committee earlier in the testimony. It omitted some of the material in the real plan which drew most of the public criticism. For instance, this cleaned-up version of the AMA campaign plan left out these juicy items:

1. Instructions for flooding the country with Fildes' famous painting "The Doctor," with a propaganda message printed under it, "as the first step in making doctors campaigners in their own behalf." (The campaign plan presented to us made it sound as though the doctors were making this campaign in the public interest.)
2. A warning to doctors against engaging in debates because "they make a forum for the opposition."
3. The AMA press agents' plan to turn out "emotional, fighting prose" rather than "dry, statistical copy."
4. The press agent's plan to turn out form letters for doctors to use in writing "personal letters" to their constituents in Congress.

It seems to me that these deliberate omissions from the AMA campaign plan presented to us hardly jibe with Dr. Goin's claim that the campaign is being conducted "openly, frankly, and honestly." Nor do many of the statements being made by spokesmen of the AMA in that campaign. I cite particularly their frequent attempt to make it appear that more than 50,000,000 Americans have adequate health insurance, when analysis shows the figure is about 3,500,000.

In Dr. Goin's own statement, for instance, he talks about 20,000,000 people being covered by commercial insurance and says "competition by Blue Shield plans has made them offer good comprehensive contracts." Now I am sure Dr. Goin knows that neither the Blue Shield nor the commercial policies offer, in most cases, comprehensive protection. Most of the Blue Shield plans are confined to surgical care alone, and the commercial policies offer cash indemnities without any relation to the cost of the medical care required. I doubt if any of them could honestly be described as "comprehensive."

Mr. PRIEST. Dr. Carl Flagstad? You may proceed, Dr. Flagstad.

STATEMENT OF DR. CARL O. FLAGSTAD, APPEARING ON BEHALF OF THE AMERICAN DENTAL ASSOCIATION, MINNEAPOLIS, MINN.

Dr. FLAGSTAD. The American Dental Association appreciates this opportunity of presenting its testimony at this particular time.

My name is Dr. Carl O. Flagstad. I have been engaged in the private practice of dentistry in the city of Minneapolis, Minn., for 38 years, during which period I also have been a professor in the School of Dentistry at the University of Minnesota where I have served as chairman of the department of denture prosthesis for many years.

The council on legislation of the American Dental Association, of which I am chairman, is elected by the house of delegates and charged with the responsibility of representing the American Dental Association before the Congress of the United States on legislation of interest to dentistry. It is my purpose today to present the views of the Association concerning the National Health Insurance and Public Health Act.

THE AMERICAN DENTAL ASSOCIATION AND ITS OBJECTIVES

The American Dental Association, with its predecessor society, has been the national organization of dentistry for nearly 100 years. Today there are more than 69,000 members of the American Dental Association, or approximately 85 percent of the dentists registered in the

United States; in addition, 70 percent of all dental students in schools of dentistry throughout the United States are student members.

The association has 53 constituent societies, which represent each of the 48 States, the District of Columbia, each territorial possession and dentists employed by the Government of the United States in the Army, Navy, Public Health Service, and the Veterans' Administration. Within the constituent societies there are 433 organized district societies. Each constituent society sends delegates to the annual meeting of the house of delegates, where the policies of the association are established through official actions by the house.

This extensive dental organization was not created to be a dental pressure group. It provides a working medium through which the dentists of this country may study problems relating to dentistry, and to the dental health of the Nation, and through which they may mutually contribute to the advancement of dental knowledge.

The American Dental Association and its component societies are dedicated to the improvement of the dental health of the people of America. That the objectives of the association have been adhered to by the membership is demonstrated by the fact that the United States has the best dental health and the finest dental care for its people of any country in the world.

The association has taken its professional obligation seriously. It has annually expended a goodly portion of its own funds for dental research. It has created and maintained fellowships at the National Bureau of Standards and at the National Institute of Health. It maintains a reserch commission at the Army Dental Museum, and through its council on dental therapeutics, devotes considerable time and effort to the study, evaluation and dissemination of information with regard to dental therapeutic agents. Through its council on dental health it continually studies the oral health needs of the public, develops plans to meet such needs and stimulates programs for promoting oral health. It maintains a comprehensive program of oral health educational services, which are available to the membership and to the public.

Dentists devote considerable time each year in attendance at the meetings of their various dental societies, for the purpose of attending clinics and lectures designed to improve their professional knowledge and skill so that they can more efficiently serve the dental needs of their patients.

Dentists, as individuals, and as a profession, have demonstrated their interest in promoting the better health of the people in the community, in the State and in the Nation. Through the efforts of the dental profession and its associations the dental health of the public of this Nation has constantly improved, and with such improvement in dental health there has also been an improvement in general health.

Dentistry has recognized its obligations. It has developed, fostered and expanded dental schools for the training of more dentists; it has contributed its funds and time to research projects in an endeavor to better the health of the population; it has encouraged and promoted the establishment of dental health program for children and adults in hundreds of cities and counties throughout the country. Through its efforts and encouragement, dental divisions have been established in nearly every State health department. The dental profession has consistently examined legislative proposals relating to dental health and has endorsed what it deems good for the dental health and welfare of the people. It has vigorously opposed legislative proposals that it considered not in the best interest of the people.

DENTISTRY'S RESPONSIBILITY

This preliminary statement has been made to assure the Congress that the dental profession is keenly aware of its responsibility in matters pertaining to the dental health of our Nation and to indicate that the American Dental Association has continually stimulated its membership to discharging this responsibility with unselfishness and efficiency.

The dental profession believes it is the rightful guardian of the people's dental health and that the profession is best qualified by training and experience to judge the value of a dental health program for the United States.

The dental profession believes it would be derelict in its duty if it did not oppose health legislation which in its judgment is detrimental to the health and welfare of our people.

The American Dental Association believes this committee and the Congress of the United States will understand that the association, in its oposition to the philosophy of compulsory health insurance, is motivated by the sincerest desire to protect the Nation against a system which the association believes will deteriorate the health services afforded to our people.

The National Health Insurance and Public Health Act is a proposal for a health program which dentistry considers to be unwise legislation. The association believes that the responsibility for providing dental care must be borne in the same manner as the responsibility for providing food, shelter, clothing, or any other essential of life.

It is the American custom and tradition for an individual to attempt to supply these for himself. If he cannot do so, the responsibility falls on the family, the community, the State, and the Nation successively. If each assumes an equitable share of the responsibility, the problem of better dental health in this country is on the way to solution. There is no more reason for the Federal Government to assume the primary responsibility for providing health care than there is for it to assume the primary responsibility for providing food, shelter, and clothing to all.

Although it is necessary for the community and Government to care for the health needs of its indigent and to aid those unable to meet the expense of protracted illness, it is a fallacy to assume the collection of money at the Federal level to be channeled into health care will make available adequate health service to everyone and guarantee an improved level of health to our people.

Undoubtedly those who are familiar with the problems surrounding the distribution of health care are aware of the limitation of a nationalized health program, but unfortunately the general public believes the proposed compulsory health insurance legislation is a panacea for the difficulties of the care and expense associated with illness. If the Congress should enact this proposal it will saddle the Government with a gigantic task which it cannot possibly discharge in the manner the people have been led to believe.

LIMITATIONS OF THE PROPOSED ACT

This bill infringes on the rights of the individual. It compels persons to contribute to the cost of a program which cannot be effectively carried out, and which will not improve the health of the people of this country. It appears that the bill fails to recognize the ultimate results which must flow from its enactment, that by its very terms it sets up conflicts which cannot be resolved without repudiating some of the promises which the bill makes.

IT IS NOT A TRUE INSURANCE PLAN

The proposed legislation is termed "national health insurance" but it is not actually insurance, because there is no sound actuarial basis to serve as the foundation of the program, nor is there any relationship between the proposed benefits and the ratio of premiums to be collected.

Actually, even the proponents of the bill cannot give a clear estimate of the amount of funds which the proposed appropriation would provide in relation to the probable costs of offering the various health services, nor do they present a convincing forecast as to the probable immediate demand for various types of services proposed to be paid for in relation to the probable cost of those services.

In considering the so-called insurance aspects of the bill, it is necessary to examine the method by which a person would become eligible for benefits. In an ordinary policy of insurance he becomes eligible when the company accepts his contract and immediately upon the payment of his premium.

Under the system proposed by the bill it must be assumed that the beneficiaries would contribute out of their wages. A formula is borrowed from the old-age and survivors insurance program to be used as the guide to eligibility. The bill provides that a person will be covered if he or she earns $150 per quarter in each of four of the first six quarters prior to the commencement of a benefit year; an alternative formula is provided for those who earn less than $150 a quarter.

It is difficult to comprehend what constitutes the relationship between the earning of $150 per quarter and the right of a person contributing taxes to the fund to receive benefits. Under the proposed system a beginning wage earner would be taxed, and yet he might have to wait as long as 18 months, during all of which time he might be making tax contributions to the fund, before he would be eligible to receive the benefits. This certainly is not insurance and the formula just does not make sense, particularly when other groups would be covered without the necessity for contributing anything to the fund.

Proponents of national compulsory health insurance claim that the Nation can solve its health problems by taking advantage of the insurance principle, which has been effective in many commercial and voluntary plans. There can be no question, philosophically, of the value of insurance to the individual and to society if the insurance plan is actuarially sound and if it does not endanger the rights, privileges, and well-being of individuals and society. Insurance as a single entity is desirable. But insurance resulting in the adoption of dangerous social philosophies, excessive costs, and lowered standards of health service is undesirable.

These proposals cannot be carried out as sound insurance practice. Insurance is a method of providing protection against loss or a damaging event by spreading risks among a large number of potential claimants. The funds collected from insured persons are used to pay insurance claims, administrative costs, and, in the case of commercial agencies, dividends. In other words, a financially sound insurance plan is based on known actuarial experience; it is self-supporting through the collection of premiums; and it guarantees stipulated benefits.

The proposed federalized health-care system must be financed, in part, by appropriations from the general revenue fund, in addition to pay-roll deductions or income taxes. The scheme would not be self-supporting, nor would it assure the provision of benefits to all persons covered under the plan. Thus, the system is not insurance, but actually is only a method for collecting additional taxes.

On numerous occasions supporters of compulsory health insurance have described the proposal as a prepayment plan. The President used the term in his message to Congress. In a strict sense, prepayment is considered to mean payment in advance of the receipt of service. The question of whether a system of national compulsory health insurance can be classified as prepayment perhaps is only an academic one. Nevertheless, the fact remains that the federalized health plan must be subsidized by congressional appropriations and that the income-tax payments alone will not pay the billions of dollars in costs.

IT WILL LIMIT DENTAL HEALTH EDUCATION

The American Dental Association believes the proposed system of compulsory health insurance would not save more lives or reduce the prevalence of illness or more effectively prevent sickness or cure diseases. The death rates and prevalence of illness and physical defects, including dental disorders, are lowered by preventive measures and by early and sound treatments. Experience has shown that in countries where the system exists the dental profession and its auxiliary aids are so busily engaged in restoring decayed and lost teeth there is no time for dental health education of the public and the stimulation of preventive measures. These aims can be reached without a system of compulsory health insurance; in fact, information from foreign countries indicates that dental health education and preventive measures for dental diseases are more effectively promoted in this country than in any other place in the world.

EVENTUALLY STATE MEDICINE WILL DEVELOP

The proposed legislation will eventually, if enacted, develop into a system of state medicine which means it will be absolutely controlled by the Government and its administrators. A third party who is directly responsible to the Government and only indirectly responsible to the patient is interposed between the patient and his dentist or physician.

Although a number of plans are proposed in the bill, which indicate that a practitioner could participate in the system on either a free-for-service basis, under the panel system, or on a salary basis, nevertheless, considering the great size and population of our country and the necessary complexities of administration involved, it does not seem reasonable that any of these systems could be continued in effect very long. The fact that the bill provides for three different methods of payment to practitioners only serves to emphasize the increased administrative costs which would be incurred. In a relatively short time it would be necessary for the Government to abandon alternative methods of payment and to insist upon a salaried service and mass clinical service in health centers.

The Government would further intervene between the practitioner and the patient by its regulatory function under which it could prescribe the type of treatment or service which could be offered and the types and kind of medicine which could be administered. That this would occur is implicit from the bill itself, which permits the reduction of services where personnel or facilities or funds are limited.

When the limitation of services to be rendered comes about, the citizen would have to make private arrangements to obtain at his own cost such additional services as he might need, and this might be difficult to secure. In the final analysis the only hope for any degree of success in the operation of the federalized health plan proposed is regimentation. Regimentation of the people as to the service they will be given and regimentation of the profession as to the service they shall render is not the American way of life.

LIMITATION OF FREEDOM OF CHOICE

The bill proposes that each patient shall have a free choice of physician, dentist, medical group, hospital, and so forth, to render the services he needs or desires, providing, of course, that the entity so selected is participating in the plan, but it does not make clear to the public that this objective may be impossible of attainment within the necessary administrative limitations of the system.

Obviously the choice of practitioner will be limited to the particular local health service area in which the beneficiary resides, and even then, within that area, whether operated on the panel, salary, or fee-for-service basis there will be practical objection to permitting each person to select the practitioner of his choice. Obviously certain professional men and certain hospitals will be in greater demand than others, but the number of patients which each can handle is patently limited; thus the patient must seek for his first choice, and if not accepted there may have to be satisfied with any dentist who can accommodate him as a patient.

Again the bill sets forth that a practitioner shall be free to practice his profession in a locality of his own choosing and that he may be free to accept or reject any patient—subject to local law and professional ethics. But we have seen in Britain and undoubtedly it would happen in this country, that in certain areas which tend to attract more professional men in proportion to population than other areas, the Ministry of Health has refused to certify new practitioners for those overcrowded areas. This may be a practical solution to the problem of overcrowding, but it is not the American competitive way where the most skilled will survive professionally and the less skilled must get along as best they may.

Under our present system of ethical competition in the health professions there is a tendency to stimulate the competitors to improve their skills in order that they may continue to be accepted by patients in the locality in which they choose to live. Where this freedom of location is denied by administrative fiat the element of professional competition from which individual economic security flows will be destroyed to the ultimate detriment of the health and welfare of the Nation.

DUPLICATION OF HEALTH SERVICE BENEFITS

The bills under consideration propose to offer a system of comprehensive health benefits to about 80 percent of the population of this country. If the bills were put into effect as contemplated nearly everyone would be entitled to obtain medical, dental, and hospital services. This, admittedly, will entail a great expenditure of money. Nevertheless, through oversight or otherwise, the bill fails to repeal, upon its effective date, the extremely costly medical, dental, and hospital services presently offered under veterans laws to veterans for the so-called non-service-connected causes.

At the present time these nonservice-connected benefits are justified on the basis of past service to the country and the immediate need of the veteran to whom they are rendered. However, if the veteran, like all of the other segments of the population, is entitled to receive comprehensive health care under these bills then there can no longer be any justification for the nonservice-connected medical benefits and in justice to the country these laws must be immediately repealed upon the taking effect of this act. Otherwise, the people of the Nation will be burdened with the expense of a costly duplication of benefits.

THE BILLS ARE NOT SPECIFIC

It is impossible to examine this bill carefully without being continually impressed with the fact that there is very little that is specific in the bill. Actually it amounts to little more than an appropriation coupled with a license to experiment along certain lines until such time as a firm base line can be determined. Yet if this is to be insurance, why is this necessary? Congress has on at least two occasions passed laws which were specific and definite insurance policies containing generally within themselves the benefits to which the policyholders were entitled. I refer, of course, to the War Risk Insurance Act and to the National Service Life Insurance Act.

It has been a principle of Government in this country since the time of the founding fathers that ours is a Government of laws, not of men, and that to accomplish that end all statutes must be definite and specific. For this reason the courts have frequently held that broad, general language might constitute a delegation of legislative authority which is reserved to the Congress alone. Yet under the pending bill nothing definite will be known until such time as administrative regulations are promulgated, revised, rerevised, and possibly at some distant future date crystalized into such form that the Congress can adopt them as a statute. The American people are entitled to know at the time of enactment of a law its probable effect and its proposed cost. Neither of these can be ascertained under the pending bills.

A DENTAL HEALTH PROGRAM FOR THE UNITED STATES

The health professions have frequently been criticized for not presenting a positive approach to the solution of health problems of our people. However, this criticism is not justified in regard to the American Dental Association for it has long recognized that there are certain weaknesses in the distribution of our dental health services and has rpeatedly appeared before the Congress to solicit its aid in the enactment of legislation which would in some degree help overcome these shortcomings. The association has no former appearances before congressional committees presented for the record a dental health program for the United States as advocated by the American Dental Association.

It is axiomatic that dental diseases affect some 95 percent of the population at one time or another during their life. The American Dental Association believes with regard to this problem that it is first important to intensify research which may lead to the prevention and control of dental diseases and thus reduce its incidence. Efforts to put this belief into practice have been made by the association, first through the use of its own funds, since 1913, for research problems; secondly, by encouraging the establishment of dental divisions in the departments of health of the various States; and thirdly, through the sponsorship of the bill which became Public Law 755 of the Eightieth Congress, creating a National Institute of Dental Research. This authorized an appropriation for a building for such institute and an annual appropriation to carry out that research. It is only by extended and intensified research that more knowledge of the causes of dental disorders can be obtained.

The association believes that another step in the solution of the problem of dental diseases is an intensified dental health education program for children and adults. Unless people can be brought to realize the importance of early treatment of dental disorders, of proper dental hygiene, and of the need for starting dental examinations early in life, the problems of dental diseases will continue to increase rather than abate.

The association believes that dental care should be available to all, regardless of income or geographical location, and that programs developed for dental care should be based on the prevention and control of dental diseases. It has recommended the following program as an immediate planned action to accomplish this objective:

One. The prevention of dental disease through the application of preventive technics as soon as they are demonstrated to be scientifically valid; the support of intensified dental research with adequate funds, personnel, and facilities.

Two. The control of dental diseases by the expansion of community dental programs, integrated in the general health program to make dental care and dental health education available to every child.

Three. The provision of additional facilities and uniform standards for dental care by making dental services available in hospitals and health centers for in-patients and out-patients.

Four. The recruitment of an annual enrollment of dental students equal to the capacity of all dental schools to increase the number of qualified dentists.

Five. The adoption of measures to make dental practice in smaller cities and rural areas more attractive and rewarding in order to procure a better distribution of dentists.

Six. The employment of dental hygienists as auxiliary aids to the dentist; the provision of additional courses for those who desire to qualify for positions in public health departments and schools.

We have not attempted to discuss in detail titles I through VI of the bill. It is true that titles I, IV, V, and VI have a legitimate dental interest, and might be worthy of comment by the association, but these titles are not offered as individual proposals to be examined on their own merit; instead, they are proposed as tools or aids to accomplish the purpose of title VII. Since the association is opposed, in principle, for the reasons herein stated, to title VII, it does not feel that it is necessary to comment in detail upon the other titles of the bill.

SUMMARY

The dental profession is opposed to the philosophy of compulsory health insurance legislation for the following reasons:

1. It is not good legislation for the Government because:

(*a*) It is too tremendous a task for the Government to administer.

(*b*) There is a misconception by the people of what the Government can and will deliver in health services.

(*c*) It will create an unwieldy Government bureau.

(*d*) It is an uncertain financial burden for the Government.

(*e*) It is contrary to democracy in government since it stifles private enterprise.

2. It is not good legislation for the people because:

(*a*) It promises more than it can deliver.

(*b*) It will cause deterioration of dental service and lower the level of health.

(*c*) The necessary administrative procedures will delay treatment.

(*d*) It will become a tax burden.

(*e*) It will eventually require regimentation which is not the American way of life.

3. It is not good legislation for the profession because:

(*a*) It will destroy competition, inhibit ambition and industry.

(*b*) It will result in mediocrity in the profession.

(*c*) Excessive paper work will reduce the number of chairside hours which a dentist may devote to his patients.

The profession needs ethical competition, the private relation to and direct responsibility for the health of the patient to attain its highest achievements.

CONCLUSION

The American Dental Association—and the dental profession—always has been and always will be interested in the health, and particularly the dental health and welfare of the American people. It will conscientiously scrutinize any programs offered which relate to its legitimate field of interest, and it will comment briefly and without prejudice or selfish motives on such programs.

The dental profession opposes the enactment of the National Health Insurance and Public Health Act because it is not good health legislation for the people of the United States of America.

Mr. PRIEST. Dr. Flagstad, I am sure that there will be a number of questions that members of the committee will desire to ask. I have some myself, but because of the lateness of the hour and the desire of the committee to hear other witnesses who have come some distance, we will probably limit the questions.

Do you have any questions, Mr. Sadowski?

Mr. SADOWSKI. No.

Mr. PRIEST. Mr. O'Hara?

Mr. O'HARA. Doctor, as a resident of your State, I am, of course, personally very proud of the fine dental institution that we have at the University of Minnesota. Of course, your very name makes me want to go back to Minnesota.

Dr. FLAGSTAD. I might say for the benefit of the gentleman from Michigan that the Blue Cross was developed in Minnesota; it had its stimulus and incentive there.

Mr. O'HARA. I am personally very happy to have had you appear before us.

Dr. FLAGSTAD. Thank you.

Mr. PRIEST. Thank you, Doctor. Perhaps when we get to title VII you might want to appear before the committee. Of course, you are welcome to appear, although most of your testimony dealt with title VII. There will be specific hearings on that title at a later date.

Dr. FLAGSTAD. Thank you.

Mr. PRIEST. Is Dr. O'Shea, president of the American Optometric Association, present?

STATEMENT OF DR. JOHN B. O'SHEA, PRESIDENT, AMERICAN OPTOMETRIC ASSOCIATION

Dr. O'SHEA. Mr. Chairman and members of the committee, it is a pleasure to appear before you. I have only about four pages here and I will go through as rapidly as I can. Thank you for prolonging the hearing so that we could be heard.

My name is John B. O'Shea and I reside at Northampton, Mass. I am president of the American Optometric Association. I am a practicing optometrist. I was previously president of the Massachusetts Association of Optometrists and have served on the Massachusetts Board of Registration in Optometry.

The American Optometric Association is the national organization representing the profession of optometry. It is set up in the same manner as are similar organizations representing other professions. The individual optometrist joins his local association. In a few of the smaller States there are no local organizations and the optometrist joins the State association directly. In the larger States there are local, district, or zone groups. Upon joining the local organization, the optometrist automatically becomes a member of his State and National associations and so also when he becomes a member of his State Association he, likewise, becomes a member of the national association.

A recent survey indicates that there are about 17,500 optometrists licensed and registered in the 48 States and the District of Columbia, of whom approximately 14,500 are actively engaged in practice. These figures are conservative because during the past several years there has been a substantial number of veterans who have returned to interrupted optometry courses and have graduated and been licensed.

There are nine accredited schools and colleges of optometry. These are accredited by the Council on Education and Profesional Guidance of the American Optometric Association and graduation from one of these accredited schools is a prerequisite for admission to a licensing examination. Just as in medicine, dentistry, and the other health professions, the statutes in the individual States provide for boards of examiners in optometry and these boards have assigned to them the functions of licensing and regulating the practitioners of optometry.

Most of the accredited schools are presently giving 5-year professional courses and commencing September 1, 1949, this fall, all schools will give a 5-year course in optometry.

Optometrists are the only persons engaged in the health field who are specifically trained and especially examined and licensed to care for human vision. Their entire educational process is devoted exclusively to betterment and the care of vision and optometrists may factually state that they are the only exclusively licensed vision specialists in the health care field.

There are two other groups which care for vision. One is the ophthalmologist. He is a physician who has specialized on the eye and who has taken and passed an examination given by the American Board of Ophthalmology. There are approximately 2,600 of this group diplomated in the United States. Ophthalmologists practice exclusively on the eye and devote the great majority of their time to pathology and surgery of that organ. Refraction or the analysis of vision and the prescribing of corrective lenses are only an incidental in the practice of ophthalmology.

I quote from an article appearing in the November 27, 1948, issue of the Journal of the American Medical Association. It is by Dr. S. Judd Beach, a member of the Ameircan Board of Ophthalmology and himself a noted ophthalmologist. The article states:

> This paper is inspired by the limited knowledge of refractions exhibited by the candidates for board examination. Even the candidates who obtain satisfactory results at the practical examinations show training confined to only one of the standard methods. Young assistants can usually operate on cataracts better than they can fit patients with glasses.

The other group is known as the occulist. Most occulists do not confine their practice to the eye but extend it to cover the ear, nose, and throat, thereby devoting only a fraction of their time to the eye. There are approximately 7,000 of these so-called eye, ear, nose, and throat specialists in the country.

Seven out of ten persons who require visual care voluntarily seek the services of optometrists and become their patients. The other three ar the patients of either the ophthalmologist or the occulist. Eminent ophthalmologists have admitted in their writings that the percentage ranges between 75 and 80 percent, but we are content to take the lower figure.

We respectfully contend that the care of vision is not an incidental phase of health care and should not be grouped with auxiliary services. I do not think that this point need be emphasized by dry statistics. The members of the committee need but think for a moment of how many people they meet daily who use eyeglasses. This is an indication that the wearer has found it necessary to obtain visual care. Suffice it to say that 70 percent of all persons over 40 years of age have visual problems necessitating the use of glasses. In addition, spot surveys made in different industries indicate that there are many people who have visual problems and who should have these problems corrected, who today through ignorance or neglect are going around with impaired vision.

The very vastness of the visual problem in the United States is such that it is not a secondary or auxiliary health requirement. It not only has health but social aspects which are equally important. Without comfortable and efficient vision, the worker cannot properly turn out his work; the inefficiency of vision lowers his productivity, decreases his own earning power, and impairs the quality and quantity of his employer's product. It was clearly demonstrated during the war that the problems of industrial vision must be met. Good clear vision not only increases the usefulness of the worker, but also tends to protect him from injury and adds to his happiness as well.

Organized medicine is one of the most powerful groups in this country. It exerts influence far beyond its numbers. It tenaciously follows one set policy, namely, that anything directly or remotely relating to the human body or human health should be exclusively under the domination and control of medicine.

Because medicine terms the care of the eye in itself a small specialized field and because refraction or the analysis and correction of vision is only a fractional part of this already small field, medicine disregards the over-all picture; fails to see or realize the social and economic aspects of good, efficient vision, and seeks to relegate the care of vision to a place of secondary importance.

Medicine has always failed to realize the importance of good vision. In 1932 a multivolume report was published on the costs of medical care. This report was the result of a study of many years by a committee appointed by President Hoover under the chairmanship of the Secretary of the Interior, Dr. Ray Lyman Wilbur, and in this report it is stated:

> The medical profession has objected to the refraction of the eye and the prescription of lenses by optometrists, since physicians considered this new work to come within the jurisdiction of medical practice. Nevertheless relatively few physicians became occulists, and, of those who did, many were quite poorly qualified. In large degree, the existence of optometry on its present basis is due to the failure of the medical profession to recognize the importance of this field and its failure to provide needed services. The training received by medical students does not qualify them to do refraction. The curriculum devotes relatively little time to the eye. Furthermore, until recently, adequate postgraduate facilities for the study of ophthalmology have been lacking.

That was published in 1932. Sixteen years later in the same issue of the Journal of the American Medical Association from which I quoted above, Dr. M. Hayward Post, Jr., of St. Louis, Mo., stated in the abstract of discussion published in connection with the Beach article:

> The older ophthalmologist often falls into a rut, and, from lack of time and greater interest in the more spectacular aspects of surgery and pathology fails to verify his refraction. The result is that the majority of older ophthalmologists are notably poor refractionists.

Despite these admitted shortcomings, medicine still jealously insists upon dominating the complete health care field and from the foregoing it must be apparent that medicine insists upon this despite the detriment it works upon the public.

In addition to its avowed purpose of completely monopolizing the health care field, the medical eye man and the optometrist are economic competitors. Only a very small percentage ranging between 5 and 8 percent of all persons whose eyes are examined have conditions which require medical attention. The other 90 percent or more need competent refractions or visual training to correct their visual deficiencies.

Medicine has always resented optometry and from its inception has sought either to extinguish it or relegate it to a subservient status.

Because optometry filled a need in the health care field which medicine either failed to see or neglected, it has become over the last 40 years, an established and important profession. Optometry is an independent profession—independent in the sense that the person who seeks visual care may of his own free will, seek the services of the optometrist without being referred to him by anybody. The patient not only selects the individual practitioner of his choice but also the type of practitioner. Because of the excellence of the service and its need and usefulness, optometry has attracted and holds at least 70 percent of the patients. They are now and should be free to select an optometrist of their own choosing.

The whole intent and purpose of the present National Health Insurance and Public Health Act states and reiterates this American plan of freedom of choice to the patient in selecting the practitioner and freedom of the practitioner in rendering his services. In the very beginning, in section 3 the bill states:

> * * * that physicians and other professions furnishing services in accordance with the provisions of this act, shall be assured full freedom in the practice of their profession, * * *.

To place the entire profession of optometry in the status of an auxiliary service subservient to medicine is inconsistent with this declaration of policy.

Section 703 of the bill is highly objectionable to the profession of optometry for this provides that whereas an individual may freely procure general medical or general dental services by applying directly to the practitioner of the individual's choice, he may only receive auxiliary services of which optometry is a part when he is referred to an optometrist either by the physician from whom he is receiving medical care or by an administrative medical officer to whom he must first apply.

Such a provision completely changes the present method of optometric care. Today an individual seeking visual correction needs go to no one in order to be first referred to an optometrist. He may and he does follow the free dictates of his own choice and that his own choice has most frequently been the optometrist is demonstrated by the 7 to 3 ratio I mentioned above. This may gripe medicine, but we respectfully contend that it is completely contrary to the public interest to attempt to utilize a bill which seeks to broaden and increase health care in order to wrench and change a practice which has been in effect for 50 years.

This bill should not be used as a vehicle to change over an accepted and established method whereby the public can procure visual care by applying in the first instance directly to the optometrist as an independent practitioner without referral.

This bill should not be employed as a means of giving medicine the right to relegate optometrists to the status of technicians. That, too, would be contrary to the public interest. Because of the independence of optometry and its freedom from the domination of medicine, the profession has advanced to the point where the vision of the American public receives better care than that of the public in any other part of the world.

Most of the advances in the science of seeing and in the correction of vision have taken place in this country and they have been the result of the work of optometrists, physicists, and other optical specialists who are not medical practitioners. To subjugate a profession which has always been independent since its inception, to the domination of another profession must of necessity stifle it, to the consequent detriment of the public.

More and more frequently in the addresses and writings of prominent physicians are found the veiled statements or threats that ophthalmology can train a lay person in 6 months to do refractions and perform the work of the optometrist. That same suggestion was made upon the hearing of then H. R. 1699, a bill which sought to create an Optometry Corps in the Army. It was laughed down then as a result of the testimony of the dean of the graduate schools of Ohio State University and deserves the same treatment today were the implications not so serious.

No clear-thinking individual can conceive that a lay person regardless of his previous educational qualifications can be taught in 6 months' time to refract, when the course in the optometry schools are today 4 and 5 years in length. If, as a result of this bill, medicine intends to train thousands of technicians and loose them upon the public after 6 months of training, this indeed would be a terrific calamity. The effect of this bill would then be a retrogression rather than a progression.

No bill, including this one should be passed if it will provide a means of reversing the progressive success which the profession of optometry has achieved in caring for the visual needs of the American public and of relegating this group who have accomplished so much for so many to the status of technicians supervised by those who have never appreciated the importance to the health and welfare of our Nation of professional refraction and visual training.

Under the guise of advancing the health and welfare of the people of this country the Congress should not deliberately take away from millions of patients the fine optometric care they are now receiving and force them to first go to a different type of practitioner or to a public official for a referral.

We have not prepared specific amendments for to do so would be a most lengthy procedure, rather do we respectfully point out that the present bill should be corrected wherever necessary in two very important respects:

(*a*) Optometry should be taken out of the class of auxiliary services; and

(*b*) Its status as an independent profession should continue without a patient having to be referred to the optometrist either by a medical practitioner or a public officer.

These requests are respectfully made because we feel that to change present conditions which have worked out progressively to the benefit of the public these many years, would result in a detriment to the public. Such is neither the wish nor desire of the Congress.

Mr. Priest. Doctor, we thank you for the suggestions and I am sure that the suggestions as to amendments will be given full consideration by the subcommittee.

Dr. O'Shea. Thank you, Mr. Chairman.

Mr. Priest. Is Dr. Ezell present?

STATEMENT OF DR. WILLIAM C. EZELL, PRESIDENT, AMERICAN OPTOMETRIC FOUNDATION, AND PRESIDENT, SOUTH CAROLINA BOARD OF EXAMINERS IN OPTOMETRY

Mr. Priest. Dr. Ezell, if it is possible for you to brief your statement, including it all in the record, and summarize your testimony, it would be most helpful. We are holding a quorum for the subcommittee for 30 minutes beyond the adjournment time in an effort to accommodate everybody if possible.

Dr. Ezell. Mr. Chairman, I will be glad to do that. In fact, if you like, I will just submit my statement and you can read it at your leisure.

Mr. Priest. That would be very agreeable and very cooperative and helpful to the committee.

Dr. Ezell. Thank you, sir.

Mr. Priest. I assure you, sir, that it will be included and when we get back for the hearings on June 7 if you care to come in for any more detailed statement, we would be very happy to have you do so.

Dr. Ezell. Thank you.

Mr. Priest. Without objection, then, Dr. Ezell's statement on behalf of the American Optometric Foundation will be included in the record at this point.

(The statement is as follows:)

Statement of Dr. William C. Ezell, Spartanburg, S. C.

My name is William C. Ezell and I reside in Spartanburg, S. C. I am a practicing optometrist, and am president of the American Optometric Foundation. I am also president of the South Carolina Board of Examiners in Optometry having been a member of this board for the past 20 years.

The foundation has been incorporated as an eleemosynary corporation and its purposes are to improve, promote, and aid optometric education by means of the establishment of scholarships, by aids and grants to schools and colleges teaching optometry, by assisting in promoting and carrying out research in optometry and allied and kindred fields and generally by the utilization of any means whereby, through increasing knowledge of the optometrist, the public can be better served and its vision receive progressively better care.

The foundation, though recently incorporated in 1947, has been the result of 10 years of study and its purpose is, among other things, to give plan and substance to the previously isolated and unrelated, unorganized gifts and grants to optometric education.

Because of this study which started back in 1936, we are convinced that the great advances which the profession of optometry made during the last 40 years came about because the optometrists were practitioners in a profession which, though allied with all other health professions, was still a separate, distinct, and independent profession. The corelation with other professions of independent theories separately arrived at is far different than domination and regimentation as technicians at the hands of another profession.

The very thing which medicine complains most bitterly about is that this bill would regiment its profession and its practitioners. Nevertheless medicine by this bill seeks to do this very thing to the profession of optometry and its practitioners.

We respectfully believe that unless optometry continues in its sphere as a separate and independent profession, the urge for improvement, the ambition for advancement, and the desire for research will be curbed if not smothered. Optometric advancement can only be attained through free optometric thought not by thought channeled or sluiced according to the wishes of another group of professional practitioners.

I agree with what Dr. John B. O'Shea, president of the American Optometric Association, has said regarding the importance of vision in our present-day American way of life of ever-increasing speed, closer tolerances and greater precision.

It is therefore a matter of grave concern to all of us in the foundation that the present bill has failed to realize the complete dependence of mankind upon the ability to see well in order to perform even the ordinary chores of everyday life.

Title I of the bill provides for education of health personnel and education in the following professions—is specifically named: "Medical, dental, dental hygiene, public health, nursing, sanitary engineering, hospital administration." I ask how can anyone being educated in any one of these fields progress if he or she has uncorrected visual problems which impair his or her efficiency or comfort? Without suitable optometric care, the student seeking to improve himself in any one of these professions might find that his vision retards him, exhausts him physically, and breaks his spirit.

It might be said that the bill goes on to read "and related professions" and that optometry might be included in a construction of this phrase. Perhaps it might be, but is it not clear that the importance of optometric health care is so great that education in this field should be fostered by directly naming the profession and not leaving it to administrative construction? Of what avail is an education in sanitary engineering if the student cannot read his text books or his charts with comfortable and efficient vision?

Likewise in title VI which provides for research in child life and grants to States for maternal and child health and crippled children's services, there is no mention in section 611 of optometric services and facilities. A child unfortunately paralyzed by polio is no more crippled than one who, because of undiscovered and uncorrected visual problems, finds himself in the abyss of ignorance unable to study or to learn, unable to appreciate the glories and beauties about him. The latter child may be rescued from his visual crippled state by the care of the optometrist. Here too, the phrase "and related services and facilities" is used. And the bill goes on to refer "particularly to correction of defects and health conditions in children of preschool and school age likely to interfere with their normal development and educational progress." Poor vision is one of the greatest defects of children of preschool and school age.

During the recent war, the Selective Service Administration issued a report which indicated that the greatest cause for rejection of adults was first, dental defects, and second, visual defects. Both of these greatly exceeded the next groupings. And so, as in adult life, in the life of children do visual defects press closely upon dental defects. Strangely enough, medical defects are in far smaller proportion than dental and visual, and yet medicine seeks to continue its control of the situation.

Most of the members of the American Optometric Foundation are optometrists, but there are also many members who are lay persons of philanthropic and public-spirited minds.

We respectfully urge that the present bill be amended so as to maintain optometry as a separate and independent profession and to provide specifically for optometric education and the care of children's vision by optometrists.

Mr. PRIEST. Next we have Dr. Griffith, vice president of the National Economic Council.

STATEMENT OF DR. H. M. GRIFFITH, VICE PRESIDENT, NATIONAL ECONOMIC COUNCIL

Dr. Griffith. Mr. Chairman, if you will ring the bell on me at the end of 5 minutes I would appreciate it because I would like to read some of this out loud.

Mr. Priest. Very well, sir. You may proceed.

Dr. Griffith. The National Economic Council is opposed to enactment of this bill. The brief statement of reasons submitted here will be supplemented by a longer statement to be filed with the committee later.

The National Economic Council is in full sympathy with any plan soundly drawn and designed to maintain and improve the health of the people of the United States, provided that such plan does not involve Government, whether State, local, or Federal, in activities not properly within the scope of Government, and further provided that such plan is not financed by compulsory taxes upon the people of the United States.

One, this bill takes Government into a field where Government has no constitutional or moral right to operate.

The kind of government established in the Constitution is not the kind of government which is empowered to take a paternalistic oversight over the individual in his relation to medical care. The regulative principle of the American society as originally conceived, and as constitutionally set forth, is the principle of liberty. The proposed legislation is consonant only to another kind of society, whose regulative principle is compulsion. That this is so, is proven by the bill's own statement of basic philosophy, as well as by the fact that inclusion within its obligations and so-called benefits is compulsory.

The basic principle of Marxism, the social philosophy upon which both communism and socialism rest, is classically stated as: "From each according to his ability, to each according to his need." This is embraced in section 3 of the "Declaration of Purpose" of this bill in the following language:

> In establishing a system of national health insurance, it is the policy of this act that those persons and their dependents who are insured under the provisions of the act shall pay for its benefits in proportion to their incomes * * *

The benefits are to be uniform for all under this bill, but the payments are to be in proportion to income. Nothing could be more explicity Marxist. And the fact that benefits are not related to the amount paid, but are the same for all, shows conclusively that this transaction has no right or title to be called insurance.

It is redistribution of income for the purpose of using one man's earnings to pay for another man's medical care, and redistributing it by the device of taxation. This is only good if a compulsory society is better than a free society. If the Congress chooses to embrace the principles of this bill, therefore, let it understand clearly what it is doing.

Two, this bill extends the power of the Federal Government over the States to a dangerous degree, and lodges most of this power in the hands of two men.

Pious expressions of desire not to exercise control from above are mere surplusage when in fact this bill provides for sweeping and rigid control. Control is lodged ultimately in the hands of those who manage the power of the purse. The States themselves, the medical profession, all those engaged in furnishing health services, as well as those who receive such services, are dependent upon the will of those who have discretionary power to give or to withhold money.

Under this bill, the States must conform to the pattern set for them by the National Health Insurance Board. If they do not do so, or if after having established plans for State administration, they are subsequently rebellious against Federal control, the Board—which administers activities under title VII—may supersede all State activities and run medical services within the State directly from Washington. If this is not a provision for effective control it is difficult to imagine one better calculated to achieve it.

But the Board itself is a mere creature of the Federal Security Agency and must work "under the direction and supervision of the Federal Security Administrator" (sec. 751 (b)). So far as title VII is concerned, he is almost omnipotent. So far as the other titles are concerned, this near-supreme power is shared with the Surgeon General of the Public Health Service, who has for all practical purposes the power of life and death over the proposed education of health personnel, practical nurse training, medical research, hospital construction, special aid for rural areas, assistance to farmers' health cooperatives, grants to States for "local health work," and the whole children's program set forth in title VI.

To these two officials is given amazingly wide discretion in spending billions of dollars each year, and of setting forth the conditions upon which these vast sums may be obtained. If the legislation now proposed is studded with occasional disavowals of intent to control, such meaningless avowals only serve to emphasize what is clear to any intelligent reader of the bill: that here is the apparatus of power, and that power conferred is power which is meant to be exercised.

Three, this bill, despite its declaimers, inevitably will regiment all hospitals, health services, physicians, and other personnel, as well as recipients of so-called benefits, resulting in poorer rather than better medical and health services for the American people.

Hospitals will be built or continued in funds only if they are obedient to the regulations of the Surgeon General. The Surgeon General must approve the curriculum of schools which receive benefits and whose graduates are to become eligible to participate. Young physicians must spend at least 2 years after graduation working where the bureaucracy directs them to work.

Physicians in the plan will be compensated in one of a variety of ways, all calculated to make compensation uniform, cutting off economic incentive to harder or better work. While lip service is paid to the right of a patient to choose his own doctor, the act itself severely restricts this in practice.

As an example, no patient can call in a specialist unless either his own health-plan physician consents, or, failing such consent, an "administrative medical officer" consents. In view of the deadening abolition of economic incentive, and of the rigid control to be exercised over all health facilities in the country by two bureaucrats, the portion of the declaration of purpose saying that "a medical dole as an answer to this problem is repugnant to the American people and would certainly result in a system of state medicine, paid for from tax funds and rendered by regimented doctors," could only have been inserted by someone with a vast and gusty sense of humor.

For the kind of system described in the declaration as "repugnant to the American people" is exactly the system which the act then proceeds to establish. It is state medicine, paid for by tax funds and rendered by regimented doctors. Any representation that this is "insurance" and not socialized medicine is a barefaced fraud. This program has as much relation to true insurance as has astrology to the science of astronomy.

A further evidence that this is not real insurance, though it is being fraudulently represented to be insurance, is found in section 771 (a). This section might lead the uninformed to imagine that setting up of a real reserve fund is contemplated.

Actually, it provides for the setting up of a phony "fund" consisting only for book entries, exactly as the so-called reserves for OASI are held. The "investments" are only in Federal bonds technically "issued" to the account, that is, the IOU of the Treasury. It may be confidently predicted that this account will be no more of a real reserve than the OASI account. The lack of such reserve means that the real insurance element is lacking from the whole transaction.

It is clear that the basic purpose of this proposed legislation is not to raise the national standard of health. It will depress that standard. The real design of this legislation is to make us take a long and fearfully costly stride into state socialism. This bill does not stand alone. With other legislation now proposed, and with which it is coordinated, it will transform the American free economy and free society into a slave economy and slave society. Even if all the material benefits promised by sponsors of this bill could be achieved, the free American economy and society is too precious a possession to exchange for them. It is better to be a freeman than a superbly healthy slave.

Mr. Priest. Doctor, thank you for your statement. There are some statements made by you with which I would certainly disagree and I am sure other members of the committee would disagree. We will have an opportunity later to discuss our disagreements. We do thank you for your appearance before the committee at this time.

Dr. Griffith. Thank you, sir.

Mr. Priest. That concludes the witnesses with the exception of our former colleague, Mr. Amlie, who said a moment ago that it was time to go home. Would you care to make any statement at this time, Mr. Amlie? I appreciate your consideration of our labors, we have been pretty congested on this program. We are happy to have you here and we would be pleased to hear from you if you care to remain at this hour.

STATEMENT OF THOMAS R. AMLIE, FORMER MEMBER OF CONGRESS, MADISON, WIS.

Mr. Amlie. I just want to answer one matter brought up about these voluntary health plans which apparently now the American Medical Association is supporting. My interest in this subject is due almost entirely to my own experience trying to raise a family. From 1929 to the end of 1946, I paid out over $13,000 for medical expenses for members of my family. During the last 7 years I have carried one of the private hospital insurance plans. In the last serious illness that I had. that policy paid out $300 where the total expense ran over $2,000 and if I had not been a lawyer I would have had to hire a lawyer to collect that $300.

I sat down and figured that if I had carried this policy since 1929, I would probably have collected about $1,200 on $13,000 of expense and if I had deducted the premiums that I would have had had to pay my protection would have been much less than 10 percent. I think that would go for all of these policies. That is not to say that these policies do not give you value for what you pay, the trouble is that when you raise a family you are then in a position where you are most likely to run into very heavy medical expense and the people who carry these policies are also people in the same situation.

They anticipate that their expenses will be above the normal because they are raising families and unfortunately when you run into a crisis such as this last war, my boys put in an aggregate of 8 years of service, the question then is, should not the man who is trying to raise a family have that cost shared by unmarried people, by childless couples and by others whose medical expenses run very low.

One trouble with private policies of course is that half of the money goes for administration. You only get with a private company something less than 50 percent of what you actually pay for. If you pay $100 you get $50 worth of protection, but in the group in which you are, unfortunately, if you were to buy a policy that would really protect you you would have to pay 5 or 10 times the amount that is charged for these various policies and of course that would rule it out because so few people would be able to pay such a sum that they simply would not be a prospect either for Blue Cross, Blue Shield, or the private insurance company and there would be no sale. So about all these companies can offer is something that amounts to about 10 percent. protection.

I know you have all been very patient and I could go on for hours on this subject because I have paid for what I learned in this field. I must say that everything I have learned has been in line with the arguments by the proponents of the bill.

Mr. PRIEST. Thank you very much. We have your statement here; would you care to have it printed in the record?

Mr. AMLIE. I will ask Congressman Biemiller about that later, Mr. Chairman.

Mr. PRIEST. Very well.

(The prepared statement of Mr. Amlie is as follows:)

STATEMENT BY THOMAS R. AMLIE, MADISON, WIS.

When I first learned of these hearings on Wednesday, May 18, I contacted the clerk of the committee and was pleasantly surprised when I was asked whether I would wish to testify before the committee. The shortness of time has not permitted me to look up details in the manner that I might have wished, but then I know that other witnesses will furnish the details, and it would perhaps be better if I confined myself to those things that I have learned as a result of 20 years of interested observation in this field. This interest on my part is based upon my own personal experience in trying to raise a family.

In the period between 1929 and the end of 1946, I paid out over $13,000 for medical expenses for members of my family. The illness of one of my boys in Washington in 1935 cost over $2,500. Some of the incidental facts showing the low medical standards that prevail in Washington, were set forth in a letter that I wrote to Dr. Parran of the Public Health Service, which was printed in the

Congressional Record for July 26, 1937, on page 1887. Incidentally, this boy served in the armed forces for 4 years in World War II.

Congressmen who advocate private health insurance as an adequate alternative to a far-reaching Federal health program do not fully appreciate the nature of serious illness in a family or the very limited range of the protection that is furnished by these policies. It is my impression that it must have been serious family illness that led the poet to write: "When troubles come, they come not one by one but in battalions."

During the past 7 years, I have carried one of the standard private hospital-insurance policies. In a recent illness of a member of my family, I collected $300 where the total cost was about $2,000. Legal objection to the payment of this amount was raised, and if I had not been a lawyer, it would have been necessary for me to have hired a lawyer. People who have tried to collect on any of these private health-insurance policies usually have the experience of finding that they are full of a great deal of very fine print that they had never paid any attention to. Had I carried the standard type of hospital insurance since 1929, I might have collected $1,200, but after deducting premiums, it is plain that I should only have had about 10-percent protection. Protection of this kind is just slightly better than nothing.

It might be argued that I was not paying the premium for any more protection than I was getting. To a large extent such a contention would be valid. Sight should not be lost, however, of the fact that the policies sold by private insurance companies to individuals pay back to the policy holder an average of only 50 cents on the dollar or less for the premiums paid. If the coverage given by a private insurance company were to be adequate, it is plain that the cost would be prohibitive for practically everyone. It is my understanding that the administrative cost of the British health program is only 2 percent. Even if the administrative cost of the President's program were to run as high as 10 percent, the overhead would be small compared with that of private companies.

There is an even more fundamental objection to private health insurance than the fact that the policy holder pays a dollar for 50 cents worth of protection. This is the fact that these various types of private and cooperative health insurance programs merely tend to distribute the cost amongst people who are trying to raise families. These are the very people who are faced with the heaviest medical expenses. In a time of national emergency, such as we have just gone through, it is the people who have raised families who are called upon to make the real sacrifices. It is not the bachelors, old maids or childless couples. Already the cost of adequate medical care has gotten so high that it is beyond the reach of a large proportion of all families as witness the large number of boys of military age who were unfit for military duty. Even if an adequate insurance program were available for families, with administrative costs at 10 percent rather than at 50 percent, the cost would be several times as great as if it were equally distributed through the whole department.

In his medical insurance message to Congress, President Truman called attention to the fact that our 190,000 active physicians are only 80 percent of what we require. With 25,000 medical students and 5,400 graduating each year, the shortage is not being lessened. The restriction of the number of doctors is a cardinal point in the program of the American Medical Association. I well recall that about 30 years ago, Professor X of the University of Wisconsin economics department, used the medical profession as the outstanding example of the "closed shop" in the U. S. A. The policy and practice that was apparent to economics professors 30 years ago has become painfully apparent to the average head of a family at the present time. While the population of the United States has increased by 42.3 percent during the past 30 years, the number of physicians and psychiatrists has increased by only 13.4 percent. At the University of Wisconsin Medical College, there are in attendance for the school year 1948–49 some 280 students. In 1928–29 the number was 291. In 1933–34 the number was 317. Other witnesses will no doubt be able to furnish detailed information as to what these "closed shop" practices have done to the incomes of physicians. It is my impression that where doctors earned substantially more than people of comparable ability in other professions 30 years ago, they are now earning several times more. This would not be too important but for the great number of American families that feel that they cannot afford medical care. In conclusion on this point, I should like to suggest that the average income of physicians is considerably higher than reported. In the Internal Revenue Department of the Treasury it is a truism that, "No profession is investigated as much as the medical profession and in no other professsion does investigation yield such rich returns." A mere reading of newspapers would confirm this observation.

While I am for the President's medical program, it does not seem to me that all parts of this program are of equal urgency at this particular time. As practical men, I should like to urge upon you the general proposition that if the bill, H. R. 4312, cannot be passed in its entirety, it is important that an effort should be made to save that portion of the measure that calls for the training of an adequate number of doctors, dentists and nurses. The shortage of trained personnel would be the principal obstacle in the way of a successful health program at this time. A program that might be highly successful if we had an adequate number of doctors, might not succeed if its administrators had to contend with a 20-percent shortage in essential personnel. In checking this point with several physicians who are in favor of the President's program, I have found that they are particularly apprehensive about the problems that might arise because of the shortage of doctors. They agree entirely that the shortage of medical personnel is the real bottleneck in the present situation and that it is the part of the whole problem that ought to be given priority.

At the University of Wisconsin Medical College, it is estimated that it costs the State $1,500 a year for each student over and above what the student pays for tuition. Costs at Wisconsin are much below the national average. It would perhaps be a close estimate to say that the cost per student in medical colleges would average $2,500 a year in an expanded Nation-wide program. Since there is nothing that the Federal Government can do to increase the number of doctors, dentists, nurses etc., other than to encourage existing medical colleges to expand—a program ought to be entered upon that would pay these schools $2,500 a year for each medical student, over and above the number now in attendance.

The Congressional Record shows that a group of four Senators introduced a bill on March 29, 1949, which proposed that medical colleges be given a grant of $300 a year for students presently in attendance and $1,700 for each new student. I doubt that this inducement would be sufficient. A well known mid-western medical college, in a State which adjoins Wisconsin, has a capacity that would permit 121 first-year medical students. However, there are only 90 students in the first-year class this year. The failure to admit a larger number is generally attributed to the pressure of the State medical society. If the State medical society is able to exert such pressure on the management of this school, would not this school under the Senators' program merely accept the $300 per student now in attendance and pass up the $1,700 for additional students?

The success of a program of this kind will depend not only on the program being generous in its grants but it must be adequate in its scope and the period for which it is to run. For instance, in Wisconsin we have the University of Wisconsin Medical School and the Marquette University Medical School. I doubt that the University of Wisconsin medical school would expand even if considerable financial inducement were offered, other considerations being absent. But the Marquette Medical School is already expanding and would perhaps expand even more if Federal aid were available. Under circumstances such as these, the University of Wisconsin Medical School would perhaps feel that it would not do to be left far behind the other medical college in the State.

When I lived in North Dakota as a boy, some 40 or 50 years ago, there were 840 practicing physicians in that State. The number is now less than half of this figure and most of the remaining doctors are old men. North Dakota has a 2-year medical college but does not have a hospital that would make possible a full 4-year course. With financial help for hospital construction and expansion of school facilities, most of the medical schools now providing 2 years of medical training could be expanded into 4-year medical schools. The President's program calls for the construction of hospitals where needed. The proper place to begin the construction of these hospitals would be in conjunction with the 2-year medical schools, for the reason that increasing the number of medical school graduates would provide the interns that would be needed in these and other hospitals. At the present time there is a shortage of 2,000 interns in the hospitals of the country. This shortage of interns for existing hospitals points up the fact that the real bottleneck in any kind of an adequate health program is the shortage of trained medical personnel and suggests further that something must be started by this Congress to remedy this situation even though it may not be possible to pass the President's whole program at this time.

It seems to me that it would be highly practicable for Congress at this time to embark upon a 10-year medical training program and offer a flat $2,500 a year per additional medical student. Even if this should cause our medical school enrollment to go up from 25,000 to 40,000 students, the cost would only be $37,500,000 per year. The cost of training additional dentists, nurses, and medical technicians would be in proportion. The only condition that would have to be insisted upon would be the maintenance of standards as set by the American Association of Medical Colleges. The cost of constructing hospitals and other facilities could be provided in part by Federal grants as recommended by the President and as contemplated by the bill introduced by the four Senators. The remaining cost might be covered by a 2 percent RFC loan to be repaid out of subsequent advances for tuition such as the $2,500 per medical student.

There are at the present time somewhere between ten and twenty thousand veterans who are not only anxious to go to medical school, but who have the capacity that would in normal times have enabled them to have gone through a first-class medical school without any difficulty. They have been given rights under the GI bill of rights but the whole thing is just on paper. In normal times, a good B student could go through medical school without trouble. At the present time, an applicant must be a high A student in order to get into a first-class medical college. During the war, when the able-bodied young men were in uniform, our medical colleges were largely filled with 4-F's who were able to get by with a C average. Now the boys who spent 1 to 4 years in the service have gotten their premedic work out of the way and are trying to achieve their life ambitions to become doctors. A great majority of these boys, who in normal times would have had no difficulty, now find that they are unable to get into any medical college since there are from 15 to 20 applicants for every vacancy. If there is an obligation owing to these boys, it must be discharged now and not 2 or 5 years hence.

Recently a University of Wisconsin professor complained that his classes had increased from forty or fifty to seven or eight hundred and that the only consideration that he could get was a larger crassroom and a loudspeaker system, but, on the other hand, the medical school could reduce the size of classes depsite unprecedented need.

I do not believe that doctors should be turned out as indiscriminately as lawyers are now being turned out. The program that has been outlined merely contemplates that the present acute shortage of doctors ought to be met in the course of the next 10 years. It was my impression 25 years ago that doctors, because of their closed-shop policies, were able to earn substantially more than people of comparable ability in other professions. The public has an interest in the maintenance of ethics by the medical profession, and for this reason I think that most people would feel that doctors ought to earn more money than other professional people. At the present time doctors are perhaps earning more than twice what people of comparable ability are earning in other professions, and the AMA has apparently set a goal of $20,000 a year for its members—perhaps realized in one State. It is doubtful if the great increase in doctors' incomes during recent years has increased the interest of the average doctor in his patient. Certainly the people with whom I have discussed this matter are of the opinion that in the case of middle-age and older doctors the result has been to make them highly income conscious.

Reference has been made to the income of doctors, because these incomes result from scarcity of doctors and refute the contention of the various State AMA's that there is no scarcity of doctors in a particular State. Also, these incomes explain why so many families feel that medical care must be dispensed with—the result being the appalling number of our young men who are physically unfit for military service. Against the restrictionist philosophy of the AMA is not only the welfare of a great majority of our people but more specifically the rights of the young men with GI bill of rights certificates who in normal times would have become doctors and whose services as doctors are needed.

Mr. Biemiller. Mr. Chairman, before we adjourn, I would like to make a unanimous-consent request. I had been under the impression, as all of us were that Dr. Goin was going to testify. There are one or two statements in his original prepared statement that I had intended to question rather thoroughly. Then on top of that he has now put in a supplemental statement in which he comments upon the national education campaign of the American Medical Association. On that matter I have a great many questions that I want to raise with

Dr. Goin or some other representative of the American Medical Association because they are now circulating hundreds of thousands of copies of a pamphlet which makes up a statement out of whole cloth and then by implication makes a scurrilous attack upon the President of the United States and upon those Members of the Senate and the House of Representatives who are either sponsors of or supporters of this bill. I think it creates a very serious situation for us.

So, I want to make a unanimous consent request that I be permitted to enter a statement immediately following Dr. Goin's statement in the record.

Mr. Priest. Since the statement of Dr. Goin, who was testifying before the Senate committee and could not be here to deliver his statement was accepted for the record, without objection that request will be granted.

Mr. Biemiller. I further hope that the chairman will extend to Dr. Goin a very urgent invitation to appear before the committee at a later date.

Mr. Priest. The Chair will extend that invitation.

(The statement referred to appears on p. 145.)

Mr. Priest. Any other questions? If not, the committee stands adjourned for this purpose until 10 o'clock Tuesday, June 7, 1949.

(Thereupon, at 5 p. m., the subcommittee recessed to reconvene at 10 a. m. June 7, 1949.)

NATIONAL HEALTH PLAN

TUESDAY, JUNE 7, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The committee will come to order.

We are meeting this morning for a continuation of hearings on H. R. 4312 and H. R. 4313, the general over-all health bills. Testimony today, and as much of tomorrow as may be necessary, will be confined to general statements on the bill or bills. Following that, as previously announced, we will take up the bill title by title.

We have as our first witness this morning the gentleman from Alabama, Hon. Laurie C. Battle. We are glad to have you, Congressman. You may proceed.

STATEMENT OF HON. LAURIE C. BATTLE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. Battle. Thank you, Mr. Chairman and members of the committee.

I am appreciative of the opportunity to testify this morning. My testimony will be general, generally against compulsory health insurance and for voluntary health insurance.

Mr. Chairman, although I realize we are not adequately meeting the great need for medical service, I am strongly opposed to the compulsory health insurance method of meeting this problem.

In my opinion, people would get assembly-line treatment of ailments that need individual diagnosis and specific care, under the compulsory health insurance program.

I can visualize long lines of people marching by the doctor's office to pick up standardized prescriptions.

I can see individuals wondering if they should be in the assembly line going by the sign that says "ulcers" or the one that says "cancer."

The preliminary diagnosis would be largely up to the patient.

There would be no come-back except to wait for the next Presidential election. People not satisfied with treatment could do nothing but get in another assembly line and hope for the best.

Doctors would tend to become mechanical dispensers of standardized prescriptions.

Instead of providing for more thorough training of doctors, dentists, nurses, pharmacists, et cetera, it would encourage superficial training for dispensing medicines.

Instead of providing training for more doctors, nurses, dentists, pharmacists, et cetera, which is absolutely necessary, it would provide training for more dispensers' helpers.

Instead of building up confidence and understanding between doctor and patient, which is absolutely necessary, this system would destroy such a personal relationship.

Instead of stimulating individual drive and initiative of doctors, a Government-operated health program would stifle and discourage them because the personal rapport, incentive, and opportunities are minimized.

The medical profession would be under political control.

No other profession has been taken over by the Government—journalists, engineers, lawyers, teachers, artists. Is this just the first step, then, toward taking over the professions of America?

It would mean another mammoth Government bureau with supermen in Washington who would purport to direct the medical activities of doctors, dentists, nurses, et cetera, in every nook and corner of our land.

Red tape wrapped around the medical profession would restrict progress rather than induce it.

In World War II I saw isolated examples of how a regimented profession might be expected to react in peacetime when it does not have the incentive of contributing to the war effort. Army and Navy medicine made a glorious contribution.

In OCS my roommate had one lung collapsed from pneumonia before the doctor would take him off active duty. The doctor insisted he was "gold-bricking."

On Owi Island I reported to the dispensary. The doctor asked what was the trouble. After a few questions about my stomach he said I must have had stomach trouble before coming overseas and there was nothing he could do about it. He dismissed me with a disgusting wave of the hand. A little later in the Philippines I was operated on successfully for appendicitis by the formula prescribed in Army regulations.

At Okinawa I had another roommate who was sick. The doctor, in sending him back to active duty, told him to go on a diet of tea and toast—a physical impossibility under the circumstances.

Mr. Chairman and gentlemen of the committee, I certainly realize that we do have a big health problem. We are told that this country has only 80 percent of the physicians it needs. And, from our present training facilities, it looks as if this shortage is not being made up very fast. There are 10 to 15 applicants for every opening in American medical schools. Many rural counties in the United States have no doctors. According to 1940 information my own State of Alabama had an average of 1 doctor for every 1,350 persons while New York, at the top of the list, has a doctor for every 500 persons. More than 40 percent of the counties in the United States had no general hospitals in 1940. Nearly a fourth of the Nation's population was not served by full-time public health departments.

No medical system in the world is better than ous, in spite of its shortcomings. We should help to adjust and adapt it to meet modern needs, and not junk it. We must not sacrifice genuine quality for theoretical quantity; rather, we should improve and expand our facilities and our know-how.

By stimulating and assisting the medical profession, I believe we can make first-rate service available to everyone at costs which everyone can afford.

In working out a program of voluntary medical care, the States need Federal assistance. Our immediate problem is to expand the already existing public and private agencies that care for the health of our citizens.

To this end the bill introduced by Senator Hill, Alabama, and others follows the right approach. With the sponsors of this bill I believe that our objectives should be—

(1) Extending hospital and medical care to those who cannot pay the cost.

(2) Encouraging every individual to protect himself through voluntary participation in prepaid hospital and medical insurance plans.

(3) Training more doctors, dentists, nurses, and other medical personnel and distributing them throughout the country.

Expansion of facilities, especially in rural areas, must be made on the basis of careful State surveys.

In my opinion these are the steps that will take us to the goal of adequate medical care for all our people.

I would like to take just a brief few minutes to tell you a little bit about the Alabama plan which has been working pretty successfully. First, I would like to say that it seems strange to want to bypass the doctor's judgment on these problems—to want to smother him in red tape and bury him in Government forms and supervision. In my home town of Birmingham we find that when the doctors are in charge of a health program we get the best results. In Alabama our organized medical profession is responsible for our public health. The result is a program that is well run and free from politics. This is the goal we are seeking on a national level: An expanded, improved system of medical care with private and public agencies cooperating and with medicine left primarily in the hands of the doctors.

Mr. Chairman, I am aware that the complete health and medical-care picture in Alabama is not good—that we lag far behind in the matter of number of doctors per patient and numbers of hospitals and clinics in the matter of private health. However, I want to point out to you how we licked our problem of public health and how the doctors ran the show, not lay intellectuals who are long on theory and short on experience.

Thirty years ago Birmingham had earned the reputation as the unhealthiest city in the United States.

We had the highest death rates from typhoid fever and colitis of any American city in 1916. Birmingham was in danger of being wiped out by the typhoid epidemic of 1916. The next year, as a result of a survey made by the United States Public Health Service, Birmingham and Jefferson County combined forces and our present city-county health department was set up. Our rapid and continued progress in public health dates from that year.

(1) Since 1917 we have made a steady reduction in morbidity and mortality rates from communicable diseases.

(2) The health department has expanded in many directions, covering sanitation, health education, child hygiene and public health nursing, laboratory facilities, venereal-disease control, and so forth.

(3) In 1946 we had 12 health centers serving all corners of the county in all our different types of areas—industrial, commercial, residential, and rural—serving all our citizens.

PROGRESS OF NEGRO HEALTH

It has been said that the health progress achieved by our Negro population in Birmingham and Jefferson County is without parallel in all history. I am told that the Negro group has made substantially greater progress in health in the past 30 years than the white group.

Since 1917 deaths of Negro children due to diarrhea and enteritis have dropped from 230 per 1,000 live births to 6.

The rate of decrease of accidents causing death has been 14 times greater among Negroes than among the white group in this period. And, while cancer and diseases of the heart today take more lives among our white population, the Negro mortality rate has decreased from both these causes since 1917.

Our progress in controlling tuberculosis has been splendid in the past 30 years, enough to prove that we have the know-how; all that is needed is the money to put it into practice. We need to expand our precautionary measures and our facilities for caring for TB patients.

Deaths among Negroes from tuberculosis in Jefferson County have gone from over 390 to 95 per 100,000 population. White deaths dropped from 81 to 22 per 100,000 population. We are worried about our tuberculosis situation, and we are looking for new means of meeting it. We attracted Nation-wide notice in 1940 with our compulsory blood-testing program, which was passed by Alabama's Legislature to implement our veneral-disease-control program. All persons between the ages of 14 and 50 are required by law to take blood tests. And in 1945 Jefferson County hit the Nation's headlines by stating a mass VD-control program, with attendant publicity and education on a large scale, the like of which had never been attempted before in an urban area.

We are proud, too, of our new city-county health department building, the first large health center to be built with funds provided under the Hill-Burton Act. And our health officer, Dr. George Denison, is recognized as a noted public health authority.

Because our public health set-up in Alabama is a departure from that found in other States and because it has brought us such a long way, I would like to tell you briefly how it works.

I understand that in 1946 Alabama was the only State in the Union where State law provides that the public health department be supervised by the medical profession. By law the Alabama State Medical Association is the Alabama State Board of Health. The State board of health elects the State health officer. In the same way, in my county of Jefferson, the board of health is made up of five physicians elected by the Jefferson County Medical Society plus the president of the county commission as an ex officio member. In our State and county the board of health is the sole authority for public health, and all enforcement of health regulations is done in its name. The entire population of our city-county health department is subject to the approval of the medical profession represented by the county board of health.

Mr. Chairman, in closing I would just like to say that I believe we should not bypass our medical profession. We should not overthrow a profession which has made such notable strides. I believe that the best solution is in the improvement and expansion of the system we already have and in a voluntary health insurance system rather than in the compulsory health insurance program.

I appreciate this opportunity, Mr. Chairman.

Mr. PRIEST. Mr. Battle, we appreciate your statement, and from my personal knowledge of the situation in the State of Alabama I feel that you are to be congratulated for the great progress that has been made in Alabama. It is my understanding that Alabama is one of only a few States in the Union that has a full-time public health service unit in every county in the State. That was true a few years ago. I am not sure that it is the situation now. And, for that achievement and the great progress that has been made, I think all those who are responsible are to be congratulated.

Are there any questions, gentlemen?

Mr. BATTLE. We, Mr. Chairman, were forced into doing something drastic by this epidemic. The method has proved to be sound, helping us to do a good, constructive, creative job. I appreciate your comments, sir.

Mr. SADOWSKI. Mr. Chairman.

Mr. PRIEST. Mr. Sadowski.

Mr. SADOWSKI. This public health service—is that given free of charge to all of the people?

Mr. BATTLE. It is given free of charge to the people who cannot afford to pay anything.

Mr. SADOWSKI. How much of it is given free of charge and how much is paid for?

Mr. BATTLE. Mr. Sadowski, the work of the public health department in Jefferson County is carried on without charge to the families or individuals served. Much of our public health program is concerned with prevention of disease—inspection of food, water, housing, and so forth. Services direct to individuals include the work of the bureau of child hygiene and home nursing, bureau of dental hygiene, and the operation of the health centers throughout the county. These services are furnished only to citizens unable to pay for such services on a private basis.

Mr. SADOWSKI. Well, I would assume, in attacking the epidemic, that must have been done on a free-of-charge basis.

Mr. BATTLE. Yes, sir.

Mr. SADOWSKI. Is that correct?

Mr. BATTLE. I think so; yes, sir.

Mr. SADOWSKI. Was any cry of socialism raised by anybody at that time?

Mr. BATTLE. I do not think so. In 1917 I was not working on this problem and was not in public office. However, I doubt if there were any cries of socialization at that time. Rather, I think it was a method of providing everybody with the opportunity to pitch in and work together to solve the emergency at hand.

Mr. SADOWSKI. But the good that was done certainly could not have been done on the basis of private endeavor alone.

Mr. BATTLE. It took the full cooperation of everybody to meet that crisis, and everybody did work together, and they were successful.

Mr. SADOWSKI. That is all, Mr. Chairman.

Mr. PRIEST. Mr. O'Hara.

Mr. O'HARA. Mr. Chairman, I appreciate our colleague's statement this morning with reference to this legislation.

Having been in World War I, I appreciate the general experiences, which, of course, is not reflective of the type of medical or dental service that we had generally, but which happened both in World War I and World War II, as we so well know.

Mr. BATTLE. That is right.

Mr. O'HARA. Is the point you desire to make, Mr. Battle, that there is a danger of the same almost brutal lack of concern, when we get into compulsory health insurance among the medical profession, as was illustrated in some of our own personal experiences in World War I and World War II?

Mr. BATTLE. Yes, Mr. O'Hara.

I am very much afraid—and these were isolated examples which I was illustrating—that we would create an impersonal atmosphere which would not produce the best results.

Mr. O'HARA. That is all.

Mr. BIEMILLER. Mr. Chairman.

Mr. PRIEST. Mr. Biemiller.

Mr. BIEMILLER. I have just one or two points that I would like to pick up in connection with the questions Congressman Sadowski asked.

Certainly, your public health service—and I want to add my praise on what Alabama has done—but certainly your public health service is an example, as you put it, of cooperation of all groups; but you yourself used the instrumentality of government to bring about the effectiveness of that cooperation.

Mr. BATTLE. But we have not bypassed the medical experience and medical profession. To the contrary, we have implemented and supplemented and assisted in helping to do the job rather than bypassing and junking all of the experience and wealth of know-how they have built up.

Mr. BIEMILLER. That is my next question. Where do you find in any place in H. R. 4312 that we are bypassing the medical profession?

Mr. BATTLE. If you set up a compulsory system, I do not think that you are making the proper use of the individual physician's initiative or encouraging it at all. I think, rather, that you are using the medical profession in a way that will cause it to degenerate instead of developing.

Mr. BIEMILLER. I think, Mr. Congressman, someone has misled you about the provisions of the bill.

Mr. BATTLE. I am not talking about the specific provisions of the bill. I am talking about compulsory health insurance. When you make it compulsory for everybody to participate in a health insurance program, I believe the results will be bad if such a program is run by the Government. How could our medical service be improved by laymen in Washington who would purport to tell the medical profession throughout the United States how to operate especially since such laymen would be mixed up in politics?

Mr. **Biemiller.** You make my point. You see, the bill does not do any such thing, and that is just the point that I want to make clear, that the bills—neither H. R. 4312 nor my bill, H. R. 4313—in any way, shape, form, or manner give people in Washington, as you put it, authority to tell doctors how to practice medicine.

Mr. **Battle.** Well, that is what I am against.

Mr. **Biemiller.** The bill very carefully leans over backward to set up professional committees of doctors and other people in the health services, such as hospital superintendents and the like, to handle problems of health service.

I recognize as well as you do the problem that is present, and I do not want laymen interfering where the practice of medicine is concerned.

The only place in which there is compulsion in H. R. 4312 and H. R. 4313 is in the collection of a pay-roll tax to create the funds for paying the bills of the doctors. So far as the practice of medicine is concerned, there is not one iota of difference between what the doctor does today and what he would do tomorrow if H. R. 4312 became law.

Mr. **Battle.** It is my opinion that in effect you are setting up a political superstructure throughout the United States which makes it possible to channelize everybody through these clinics, and so forth, to be serviced in an impersonal manner.

Mr. **Biemillier.** But the bill does not create clinics. It does not create salaried doctors. It says that each patient has a free choice of physicians; each physician has a free choice of patients. How does that set up any clinics or any assembly-line medicine?

May I say to you Congressman Battle—and I mean this in no mean sense—that you ought to check those sections of the bill very carefully, because, unfortunately, the position which you are taking here today is a misrepresentation of the bill that has been widely circulated.

Mr. **Battle.** Well, I am not trying to misrepresent anything, and I just want to make it clear that that is what I am against, irrespective of any provisions in this bill.

Mr. **Biemiller.** As to that, I agree with you.

Mr. **Battle.** O. K.

Mr. **Biemiller.** And, if this bill had in it what you say it has, I would be the first one to object to it.

Mr. **Battle.** I did not say specifically what this bill had in it. I just said what I am against, and I reiterate it.

Mr. **Biemiller.** With that, I agree with you.

Mr. **Priest.** Are there any further questions?

Mr. **Sadowski.** I would like to make one observation, Mr. Battle, and that is that medicine as practiced in the Army as compared with medicine as it would be practiced under this bill, is not a fair comparison because in the Army GI Joe did not have much to say about it. Ordinarily, the doctor that he reported to wore the uniform of a captain or a major, and poor old GI Joe just had to take it and did not have a great deal of choice about the matter either. But here is a medical program that would be operated by civilians; not under Army regulations; and certainly civilians are a very beefy group of people. They can be counted on to beef at all times and in all manner of methods, as every Congressman knows by the mail that he gets, that they are the best beefers in the world, and I would think that they would continue their process of beefing if anything went wrong with this medical health insurance.

Mr. BATTLE. Who would they beef to? The United States Government. What would they wait for? The next Presidential election, 4 years hence, to make changes.

Mr. SADOWSKI. You mean to overthrow the program?

Mr. BATTLE. To change the system.

Mr. SADOWSKI. Well, by that time, I think we would know——

Mr. BATTLE. They would have no method of doing anything themselves. They could beef to the Government, but it takes a long time for the Government to clear up a "beef," as you know. A medical emergency might not wait that long.

Mr. PRIEST. Are there any further questions? Mr. Wilson, do you have any questions?

Mr. WILSON. I have no questions.

Mr. PRIEST. Mr. Battle, we appreciate your appearing before the committee. You are always welcome here.

Mr. BATTLE. Thank you, Mr. Chairman.

Mr. PRIEST. The next witness is Dr. Marjorie Shearon. I notice on the list of witnesses here—and I will say again that I hope that we will be able to stay within the time—that you would need 30 minutes for your statement. Is that substantially correct?

STATEMENT OF MARJORIE SHEARON, PH. D., EDITOR, AMERICAN MEDICINE AND THE POLITICAL SCENES, CHEVY CHASE, MD.

Dr. SHEARON. Mr. Chairman, that is correct, if I speak and do not read my testimony. I shall be very happy to do that, with one stipulation, if I might ask that my testimony be incorporated in full in the record as though I had given it and be printed in the large type and not the small.

Mr. PRIEST. Is this your testimony?

Dr. SHEARON. That is my printed testimony; yes, sir; eight pages. Maybe I had better read it.

I am appearing in the public interest to oppose H. R. 4312. My qualifications as an expert are as follows: For the past 17 years I have been engaged in research, administration, and legislative activities at Federal, State, and local levels. I spent 9 years in the executive branch of the Government, 5 in the Bureau of Research and Statistics in what was then the Social Security Board, and 4 in the Public Health Service. From 1945 to 1947 I served as Senate consultant on social security and health and in 1947 was health consultant to the Senate Committee on Labor and Public Welfare. While Senate consultant I attended more than 50 sessions of hearings on the Wagner-Murray-Dingell bills for social-security medicine in 1946, 1947, and 1948. At the request of the Senate Health Subcommittee I testified on S. 1320 for six full sessions in 1948. I have made a special study of compulsory health insurance legislation with respect to the methods of administration and costs. I am editor of American Medicine and the Political Scene, a weekly release dealing with social security, health and medical legislation, public finance, the operations of the Federal

Government, and the activities of the Government and non-Government lobbies working to establish state socialism in the United States. I am the author of numerous articles on social insurance, including health insurance, and I wrote the economic brief used by Robert Jackson in 1937 in his defense of the Social Security Act before the Supreme Court.

This is the first time hearings on complsory social-security medicine have been held in the House. I shall, therefore, address my testimony to three phases of the legislative proposals: (1) The lobby for the nationalization of medicine, (2) the origin of the legislation, and (3) methods of administration, costs, and major objections to a compulsory system of social-security medicine.

LOBBIES FOR THE NATIONALIZATION OF MEDICINE IN THE UNITED STATES

If you will turn to the charts accompanying this statement, you will be able to follow me. I also have a large chart here which I had intended to speak to, but if you will follow the chart, it will serve just as well.

Development of non-Government lobbies to nationalize medicine.

Since Congressman Dingell opened these hearings with a lengthy discussion of what he termed the "lobby" to oppose national health insurance, it seems fitting to acquaint the members of this committee with the facts concerning the lobbies working to nationalize medicine in the United States.

The movement to place the practice of medicine under Government control in the United States goes back about 35 years when there was some agitation for health insurance legislation at the State level. In 1911 Britain had passed its National Insurance Act and Czarist Russia had enacted similar legislation. It was in this period immediately before, during, and after World War I that a social planner in Massachusetts, Michael M. Davis, started discussing the question of socialized medicine. As far back as December 20, 1916, Davis took the affirmative in a debate on socialized medicine. However, there was little interest in the subject at that time and for a decade afterward.

I would not go into this if Representative Dingell had not felt it so important that he opened these hearings with a 2-hour discussion with what he called the medical lobby and did not devote any time in discussing the bill, so I shall devote my first discussion to the lobby for the nationalization of medicine.

I might say at that point that two other people, Arthur J. Altmeyer, in Wisconsin, now Commissioner for Social Security, and Isadore S. Falk, wrote the paper on compulsory health insurance in 1918, and Arthur J. Altmeyer wrote the report in conjunction with John R. Commons, in Wisconsin, on the same subject, Health Insurance, but they did not enter the field actively at that time.

In the late twenties Davis renewed his efforts to bring about Government intervention in the field of medical care. He was instrumental in helping to organize a group known as the Committee on the Costs of Medical Care—and if you will look at the diagram, it is very important that you see this—the Committee on the Costs of Medical Care is a little below the center of the chart. It was operated from the years 1928–32. Michael M. Davis was on that committee, as was Falk, and some others of the staff to whom I will refer later,

It was in that undertaking that he showed his genius for raising money from foundations and private philanthropists. All told, upward of a million dollars was contributed to that committee by eight foundations including the Julius Rosenwald Fund, the Milbank Memorial Fund, the Rockfeller Foundation, and the Twentieth Century Fund. Davis was not only an organizer of the Committee on the Costs of Medical Care in 1927, but he was also a member of its executive committee.

At that time Davis was director of Medical Services of the Rosenwald Fund, which he had joined in 1928. From 1929 to 1936 the fund spent $848,071 on medical services activities, including surveys, studies, research in social medicine, and the writing and distribution of some 160,000 pamphlets and articles. These included background material about sickness insurance abroad, social medicine in Germany from 1779 to 1932, paying sickness bills, et cetera. In other words, the period from 1926 to 1934 was marked by the organization of private groups for study and research in medical economics and by the gathering of a sizable body of documentary material. The eight foundations already mentioned spent approximately 1¾ million dollars on this ground work in medical economics and social medicine. The Committee on the Costs of Medical Care published 28 volumes, devoting considerable space to compulsory health insurance versus voluntary methods of dealing with the economic side of medicine.

Michael Davis was joined in his activities in 1929 by a man some 20 years his junior, Isidore Sydney Falk, who became Associate Director of Research for the Committee on the Costs of Medical Care. Both men held Ph. D. degrees but were not trained in medicine. The association of those two men in the late 1920's marks the real beginning of the movement to nationalize medicine in the United States. During the succeeding 20 years they have worked more or less closely together. They have not always agreed on the rate at which their program should be pushed, nor about methods, but in recent years they have acted with considerable unanimity as to objectives, plans, and procedures.

Working at first through foundations, funds, and committees, these two men in the early 1930's had access to well over $2,000,000. When Davis left the Rosenwald Fund in 1936 he received a gift of $165,000 which enabled him to organize the Committee on Research in Medical Economics. This committee is still functioning, thanks to liberal donations from the Rockefeller Foundation and from the Albert and Mary Lasker Foundation.

After completing his work with the Committee on the Costs of Medical Care in 1933, Falk became research associate with the Milbank Memorial Fund, 1933–36. As far back as 1934, Falk began to deliver talks on compulsory health insurance. During the past 17 years he has published or delivered some 83 papers and articles which for the most part have urged establishment of national compulsory health insurance. In 1934 Falk delivered a paper entitled "Formulating an American Plan of Health Insurance" at the annual meeting of the American Association for Labor Legislation, which is a policy-forming, lobbying organization which has consistently favored passage of compulsory health insurance legislation. In that same year, 1934, the research staff of the Milbank Fund stated that—

> only in large-scale compulsory health insurance—

could they see—

> the necessary and sufficient stimulus for widespread improvement in medical practice.

It was in that same year that Harry Hopkins came out for a compulsory program saying:

> You aren't going to get health insurance if you expect people to do it voluntarily.

Development of Government lobby to nationalize medicine: In 1936 Falk entered the Federal Government, taking a small job in the Social Security Board of that time. Before long he had moved into the position of Director of the Bureau of Research and Statistics with a staff of 196 persons and a Federal appropriation of nearly half a million dollars in 1941. He appointed Michael Davis as a consultant, but Davis, paid on a per diem basis, remained outside the Government, thus being beyond the reach of civil service and Federal laws relating to lobbying by Government employees. Various persons who had been with Falk on the Committee for the Costs of Medical Care moved into the Government at about the same time he did. Some are now in Social Security, some in Public Health. Since he came into the Federal Government nearly 13 years ago, Falk has had at his disposal in Federal appropriations upwards of $2,000,000. Not all of this has been spent in lobbying for the nationalization of medicine, but a considerable part of it has been so spent. His staff since 1938 has been writing the health and medical provisions of the successive Wagner-Murray-Dingell bills, including H. R. 4312 now under consideration by this committee. They have prepared research memoranda designed to show that the present system of medicine in this country is faulty and inadequate. His statistics and interpretations have been successfully challenged at the long hearings held before the Senate Committee on Labor and Public Welfare. It was demonstrated he had grossly misrepresented health conditions in this country. For more than a decade he has sought to make the public and Congress believe that there is a great national emergency in matters relating to health, whereas those who are more competent to speak say that our national health is the best in the world. Falk has consistently disparaged the United States and has played up systems of medicine found in totalitarian countries like Russia, Germany, and Japan.

Thus, gradually over a period of 20 years, two main lobbies for the nationalization of medicine have been developed. They are closely integrated and work in perfect unison. One lobby is outside the Government, the other inside. Davis heads the former, Falk the latter. Davis is now de facto leader of the Committee for the Nation's Health, most powerful of the private lobbies, and of the Committee for Research in Medical Economics.

These lobbies are listed down in the right-hand side of the charts, and I will refer to them more in detail; but you can see the line-up, those that are nongovernmental and those that are governmental.

The two men, working together, are able to draw on both private and public funds. It would be impossible to say with entire accuracy how much these two lobbyists have spent or have caused to be spent by others during the two decades they have been trying to force on the American people a Socialist type of medical practice under a system of national compulsory social-security medicine. The outlay, conservatively estimated, must have been between 10 and 20 million dollars. Some 10 or more foundations have contributed to Davis' support through the years. Private individuals and philanthropic groups have contributed sporadically. Falk has not only had his own appropriations but has made heavy use of staff in the Public Health Service, and in the Departments of Labor, Agriculture, State, War, et cetera. He, and more recently the Federal Security Administrator, has distributed thousands of copies of memoranda, booklets, and articles designed to sell the idea of compulsory health insurance. His staff has written radio talks, magazine articles, and reports for Congress. The theme has always been the same—namely, that the only answer to our national health problems is the establishment of a system of compulsory health insurance.

The International Labor Organization: But this is by no means all. Falk and his superior, Social Security Commissioner Arthur J. Altmeyer, have for 15 years been working hand in glove with the Socialist-dominated International Labor Organization. As you will recall, the ILO was created in 1919 as a subsidiary to the League of Nations. We did not join either organization at that time. The first director of the ILO, Albert Thomas, was the leading French Socialist of his day. From 1919 to 1934 he traveled throughout the world preaching the Socialist Gospel of Geneva. An ardent believer in state socialism, he sought to establish a comprehensive system of social security for every country in the world. The system was to include compulsory health insurance.

The ILO made converts in this country: In 1934 Frances Perkins suggested to President Roosevelt that the United States should become a member of the ILO. He gave his blessing and told her to see if she could sell the idea to Congress. She sold it. Congress, without adequate discussion of the legislation and of what was involved, passed a bill in 1934 authorizing the President to accept membership for the United States in the ILO. We joined that Socialist organization within a few weeks after enactment of the law. In so doing we obligated ourselves to conform our social legislation to principles laid down in Geneva. We have been doing that ever since. The Social Security Act itself, passed in 1935, was drafted with the help of experts from Geneva. It was not an American piece of legislation. We in this country have never favored compulsory measures affecting our daily lives except in time of war. The Social Security Act is designed to lead ultimately to complete control by the Federal Government of every individual in this country. Part of that control is intended to cover medical care and hospitalization.

The Communist International Workers Order: It is to be noted that the International Labor Organization is not the only organization seeking to nationalize medicine. A large number of Communist and Communist-front organizations in this country are also demanding a national system of compulsory social security for the entire population. Their demands include compulsory health insurance. Probably most of you are aware of the fact that the Communist Party was organized in the United States in 1919, the same year the ILO was set up in Geneva. In 1930 the International Workers Order was set up in New

York City as a Communist transmission-belt organization to carry out orders from Moscow. By 1943 the IWO had 162,000 members. Their Communist activities were hidden behind a fraternal insurance business. In 1943 their assets were nearly $3,000,000. In that year they raised over $400,000 for activities which have been labeled by the Attorney General as in the main subversive.

The IWO since 1930 has strongly advocated compulsory health insurance. So did the Communist International in 1936. In 1932, the IWO, urging support for the Communist Presidential and Vice Presidential candidates, said:

> Social insurance is the imperative need of the hour.

This was in 1932.

> A vote for William Z. Foster for President and for James W. Ford (Negro) for Vice President, a vote for the Communist candidates and platforms is a vote expressing determination to fight for social insurance and to support a party that leads the fight for social insurance.
>
> Members of the International Workers Order, unite your political strength on the principles of our organization: For social insurance. On the basis of our common interests let us unite our political action in this election campaign with all the workers, native and foreign-born, black and white, under the leadership of the Communist Party. Vote Communist.

In another document put out by the IWO at the same time appears these statements:

> Capitalism and sovietism are opposite poles * * *. The Communist Party is the only party which combines parliamentary and nonparliamentary methods in one great class struggle of the workers for the improvement of their conditions at present, for making the capitalists bear the burden of the crisis and for ultimately abolishing capitalism and introducing a soviet system.

I wish to quote from my chart, one further thing:

> INTERNATIONAL WORKERS ORDER
>
> This group claims "the Communists are concerned with creating a revolution" and that the IWO "is an organization that allows Communist leadership to drive its roots into the uncharted depths of the American working masses." The IWO is to establish "working-class rule in the place of existing class rule."

This is for the United States. This is the Communist program for the United States.

Now, in 1947 the Communist IWO supported the Wagner-Murray-Dingell bill of that year (S. 1320 of the 80th Cong.) and inserted a large ad in the Communist Daily Worker, summarizing the provisions of the bill and urging workers to support it. The IWO in the ad told how it had supported Senator Wagner and had participated in the Government's National Health Conference in 1938. The IWO stated it had "endorsed and supported" the Wagner-Murray-Dingell bills of 1945 and 1946. In the large ad of May 25, 1947, in the Daily Worker the IWO gave assurances that—

> Our order and its 14 societies and our entire membership (175,000) in 1,800 lodges are swinging into action in support of the new bill.

In 1944 at the sixth IWO—Communist workers convention—Representative Marcantonio, a member of IWO, was an honored guest speaker as was Senator Murray. That is the organization that is dedicated to the overthrow of the United States Government. That same year, Senator Wagner wrote the IWO thanking the organization for its support. The IWO was particularly singled out by Senator

Murray to receive an invitation to the health hearings on S. 1320 in 1947–48. The IWO sent the Russian-born Communist, Ernest Rymer, to represent them and to testify in favor of S. 1320.

The IWO has spent large, but not fully recorded, sums for the promotion of its social program. It has made gifts to at least nine Communist-front organizations. To show how this lobby operates and how interlocking memberships and directorates bring the Federal Government and the private lobbies into close working relations with the Communists, I shall mention just one notorious Communist-front organization, the Friends of the Abraham Lincoln Brigade. This organization raised considerable amounts of money to be spent for promoting Communist activities in the United States, according to the House Committee on Un-American Activities (see 1944 reports, p. 750 ff.) This brigade received over $5,000 1 year from the IWO. Among the members of this brigade were Ernst P. Boas, M. D., chairman of the Physicians Forum, a lobby to promote enactment of the Wagner-Murray-Dingell bill, a member of the committee for the Nation's Health, and a member of Ewing's medical care committee at the National Health Assembly. Among the sponsors of the fund-raising campaign for the brigade was one, Jacob Fisher, a member of the staff of the Isidore S. Falk of Social Security Administration. Fisher has been under fire and was singled out by the House Un-American Activities Committee for investigation. He is still on the Federal pay roll, having been whitewashed by Federal Security Administrator Oscar Ewing.

In addition to the Committee for the Nation's Health, there is a second lobby working for the nationalization of medicine. This is the Physicians Forum, headed by Ernst P. Boas, M. D., well-known Communist-front member. This lobby in 1945 reported a special gift of $10,000 for promotion of the Wagner-Murray-Dingell bill. The group has had other gifts which have enabled it to print 50,000 copies of one pamphlet which was used by the AFL and CIO. The pamphlet For the People's Health is loaded with dishonest and misleading statements. This is the kind of fallacious propaganda that is being fed to American workers. It is significant that this lobby, which boasts of gifts to enable it to promote the Wagner-Murray-Dingell bill, has not yet registered with the Clerk of the Senate and of the House, as required under the Reorganization Act. It is of further interest that Dr. Milton I. Roemer of the United States Public Health Service was, and perhaps still is, not only a member of, but also a national councilor for, this lobby. This is in contravention of title 18, section 201, United States Code, relating to lobbying by Federal employees.

I may summarize this section on lobbying by stating that there are three main non-Government lobbies supported by private funds and one Government lobby with cells in the Social Security Administration, the office of the Federal Security Administrator, Oscar R. Ewing, and the Public Health Service. The State Department is involved on the international level through the United Nations and the International Labor Organization as well as the Pan American Union and the Inter-American Conferences on Social Security. In testimony as brief as this, it is impossible to cover the world-wide network of lobbying into which the United States has been drawn in connection with social-security legislation and compulsory health insurance. The lobbies for the nationalization of medicine appear to have spent somewhere between 10 and 20 million dollars during the past two decades. It may be a great deal more. We do know that public funds have been spent lavishly by the Federal Security Agency and the State Department.

Now, in order to shorten this, I would refer to this chart, a separate chart, which shows the committees during the past 20 years through which the main lobbies have worked. It takes the entire page to list the committees, the foundations and funds through which the lobbies have worked.

The Senate Committee on Expenditures in the Executive Departments in a report on United States relations with international organizations (Report No. 1757, 80th Cong., 2d sess., 1948) noted that the United States holds membership and participates in the activities of 46 international organizations. It cost this country over $100,000,000 in 1948 thus to participate. A portion of this money is being used throughout the world to promote social-security programs, including compulsory health insurance. For instance, in 1948 we contributed over 3.5 million dollars to the UNESCO—United Nations Education, Scientific and Cultural Organization—which is working diligently on programs for national compulsory social security, including socialized or nationalized medicine. We contributed over half a million dollars that year to the ILO. A large part of that organization's work relates to establishment of principles for social security to be incorporated in the laws of member nations of the ILO. We are such a member nation. We stand committed to make our laws conform with ILO principles. Our Federal officials spend a large amount of their time working to bring our laws into conformity with the Socialist principles of Geneva. The United States contributes about $360,000 a year to the Pan American Union and over $13,000 to the Inter-American Committee on Social Security.

The point I am endeavoring to make is that a small group of well organized lobbyists, under the leadership of Falk in Social Security and Davis of the Committee for the Nation's Health, have had access to large sums of money, to professional staff, to promotion experts, and to research staff over a period of two decades. The amounts available may have been half a million or a million a year. Certainly more has been available during the past 5 years than before. Federal employees have been sent all over the world to promote compulsory health insurance. A mission composed of FSA officials was sent to Japan in 1947 to impose a Wagner-Murray-Dingell bill on the Japanese. The War Department paid the expenses. In addition, large sums have been spent by the Communist Party and by Communist-front organizations. There are more than 1,000 such organizations in this country. They follow the party line; that is, the Moscow line. That means they are working for establishment of comprehensive social security in the United States.

Between 10 million and 20 million dollars has probably been spent in this country since 1929 to bring about the nationalization of medicine, in accordance with principles laid down in Geneva and Moscow. Now when Representative Dingell opened these hearings by castigating the medical profession for finally assessing itself in an amount of about 3.5 million dollars for the purpose of educating the American people about the superiority of American medicine and about the deficiencies of compulsory health insurance, I believe Mr. Dingell was directing his barbs in the wrong direction. It would appear that the medical profession, belatedly to be sure, has awakened to the danger of this insidious, well-heeled lobby designed to change the practice of medicine in the United States and to create a system of police-state medicine of the type found throughout the world in totalitarian countries. Indeed, there is clear evidence this lobby is working toward a much broader revolutionary plan than the nationalization of medicine. I submit to the committee that the medical profession is performing a public service for which it should be commended. The amount they are raising and spending for their educational campaign is a drop in the bucket as compared with what Falk and Davis and the Communist Party have raised and spent back through the years. To those expenditures we must now add what Oscar Ewing is spending from tax funds to promote compulsory health insurance legislation.

Mr. SADOWSKI. How many thousands of these pamphlets have you had printed?

Dr. SHEARON. All told—I have six documents. I have printed 40,000. I sold 30,000. Part of them at least I gave away, a good many of them. I operated the first 18 months in the red when I started my little business. I publish a weekly paper.

THE ORIGIN OF THE LEGISLATION FOR NATIONAL COMPULSORY SOCIAL SECURITY MEDICINE

Historical résumé: I shall not attempt at this time to go back to the Bismarckian origin of the bill before you. Compulsory health insurance has been developing for about 65 years. Throughout most of the world the laws have been designed to force low-income workers to pay compulsory taxes which were shared by their employers and sometimes by the state. In return for this acceptance of compulsion, the workers have been given small cash benefits and so-called free medical care. When the system was started in Germany, there was no state subsidy. Labor and management footed the bill; the government provided the compulsion. The medical-care program was called sickness insurance, because primary emphasis was placed on providing a physician for the worker when ill. Professional people and workers in the better income classes were usually exempted entirely. Farmers and agricultural workers also were often exempted. There was no attempt to make the system universal. Consequently it was possible for physicians and dentists to do a certain amount of insurance work and still to have considerable latitude in their private practice.

We must recognize that the countries which instituted compulsory health insurance were unlike the United States. In some countries the people had long been used to going to public hospitals. We, on the other hand, pride ourselves on our fine voluntary or private hospitals. Other countries which instituted compulsory sickness insurance schemes tended to spend relatively less money on preventive medicine and public health activities than we have spent. Emphasis was on sickness rather than on prevention. They had far fewer physicians and dentists per 1,000 of population than we have. They had fewer hospitals. They used midwives for the delivery of babies. Specialist care was the exception. The people had not been educated as ours have been to think about health measures and healthful living. So it was natural for them to accept with complacency, and even with gratitude, a type of medical care that our population would have scorned.

It is strange, then, that there should have been this agitation to change completely the form of medical practice in this country and to adopt a system which has been tried elsewhere for 65 years and has not produced as good results as we have obtained with our free and untrammeled medical profession. However, if you consider the types of persons who are agitating for compulsory health insurance, you will be better able to understand this legislation now before you.

Students of the subject recognize that compulsory health insurance has nothing to do with health or with insurance. It is a taxing device, pure and simple. It has never resulted in producing more health personnel or in redistributing physicians, dentists, and nurses. Health insurance has tended to crystallize the practice of medicine, to make it rigid, to retard research, and to lower the quality of medical care by turning physicians and surgeons into pen pushers. The legislation has appealed to ministers of finance, to bureaucrats seeking power, and to a motley horde of persons who have seen the possibility of obtaining lucrative jobs for themselves. Furthermore, compulsory health insurance has been a vote getter, because the people have been told they would get something for nothing or nearly nothing. The scheme has appealed to Communists and Socialists because they see in it what Bismarck saw. They see that the scheme tends to attach the workers to the State. In other words, the workers today, even as in Bismarck's day, are being bought by the small bribes—the cash benefits and the "free" medical care. In every one of life's contingencies the workers would look to a beneficient Government.

The bill you are now considering has gone through a considerable evolution since Senator Wagner introduced a simple grant in aid bill in 1939. The principles underlying this bill were laid down in Ottawa in 1943 when four of our Federal officials: Arthur J. Altmeyer, Wilbur J. Cohen, Isidore Sydney Falk, who is largely responsible for the several versions of the Wagner-Murray-Dingell bills, and Mr. Perrott of the United States Public Health Service met with Cradle-to-Grave Beveridge to lay down principles for the nationalization of medicine. Those principles were presented to the ILO meeting at Philadelphia the following year. They were approved, and copies were sent to our President. He forwarded them to the Congress in a special message.

The principles approved by the ILO in 1944 are just trickling down to Congress in this and related bills. For those of you who are of the opinion that this bill if enacted would not destroy the private practice of medicine and lead directly to complete socialization or nationalization as in Britain or Russia, I shall point out a few of the principles and the way in which they have been written into the bill.

Those principles, I might say, were published in this official bill, published in June; June 1, 1944, in the ILO. There were 114 principles.

I might say that this is extremely important for the committees of Congress to realize that you cannot understand this legislation, the legislative programs, simply by reading the bills. One has to understand the full plans for administration of the program. One has to understand the rules and regulations of a compulsory sickness insurance scheme. Those rules and regulations do not appear in the basic statutes. They are written after the law has been passed. But they have the force of law without ever having been discussed in Congress, and they have been the thing that have caused the trouble throughout the world.

Now, it is perfectly posible if you look at the bill to say, "Oh, the bill does not say a word about this." No, the basic law in all of the countries that have such laws do not say anything about thousands of matters that affect the administration of the program. All of those things appear in the rules and regulations. They had 2,000 such rules and regulations in Great Britain. They now have a great many more.

ADMINISTRATION AND COSTS OF FEDERAL PROGRAM FOR SOCIAL SECURITY MEDICINE

Principles underlying program for compulsory social-security medicine: The ILO advocates, and our Federal Security officials are in agreement that as soon as possible all medical and health services shall be made available to the entire population under a system organized and controlled by the Government. The ILO laid down 114 principles for establishment of a Government medical care service. As a member nation of the ILO, we are committed to conform our legislation to these principles among whic are:

1. Medical care should be provided either through social insurance or through a public medical care service.

That is a tax-supported service. And I might state that the ILO has stated that it was not interested in the voluntary efforts that any company might make but only in Government plans, which might be applied either through a compulsory insurance scheme, or through a complete tax service.

2. Where medical care is provided through a social insurance medical care service, it should be financed by contributions from insured persons, from their employers, and by subsidies from public funds.

That, of course, is implicit in this bill, which, of course, does not include the taxing provisions, because if that were the case it would have to go to another committee.

3. "Where medical care is provided through a public medical care service:

"(*a*) Every member of the community should be entitled to all care provided by the service";

That is, a service supported by general revenues.

"(*b*) The service should be financed out of funds raised either by a progressive tax specifically imposed for the purpose of financing the medical care service, or of financing all health service, or from general revenue.

4. "Where the whole of the population is to be covered by the service and it is desired to integrate medical care with the general health service, a public service may be appropriate."

Now, for those of you who are perhaps not used to the lingo in this field, I might explain that fourth one, which is the principle that it mentioned in the bill as the guiding principle of the Congress of the United States. It says here, "Where the whole of the population is to be covered." And that is the ultimate intent of the Wagner-Murray-Dingell bills. And when there is to be integration of the medical care with the general health services, then "a public service may be appropriate."

In other words, it is well recognized that when you cover the entire population for medical care, and you combine that medical care administration with the administration of the public health services, there is obviously no reason for the selectivity that is involved with an insurance program, where each person has to be certified as being eligible for the benefits. I mean, you have to indicate in some way that you have paid your taxes into an insurance scheme; and there are many exclusions, many persons who don't get in under the insurance scheme.

But if your object is to cover the whole population, you don't have an insurance scheme. You simply pass on over to the total tax-supported scheme such as you have in Russia, or such as you now have in Great Britain and New Zealand.

5. "Where medical care is provided through a public medical care service"—that is, a tax supported scheme—"the provision of care should not depend on any qualifying conditions, such as payment of taxes or compliance with a means test and all beneficiaries should have an equal right to the care provided."

In other words, you just get the care. It is a free medical service without any qualifying conditions. Some of them pay for it through taxes. Many don't. But they all get the service.

6. "Care should preferably be furnished by group practice at centers of various kinds working in effective relation with hospitals."

That means that it is the ultimate desire of the scheme to provide the service in group practice at centers; that is, at public health centers. That is the reason why there is this present demand on Congress to provide large sums of money for the next 3 years, in order to build public health centers and public hospitals, so that the machinery may be ready for the compulsory insurance scheme when and if it goes into effect.

In simple terms, the plan is this: The Government, as soon as feasible, is to take over the entire organization of medical care. During the next 2 or 3 years public hospitals and health centers are to be built. Personnel is to be trained at public expense so that the Government may force physicians, dentists, nurses, et cetera, who have accepted Federal fellowships, to practice where the Government tells them to. That is what they have done in Great Britain. They have passed an administrative order there that persons may be sent anywhere in the United Kingdom if the Government thinks it wise. And that applies to doctors as well as to slave labor.

A capitation or panel system is to be set up at the start with gradual conversion of the system to a salaried service. I should explain that while the bill, shall we say, goes through the motions of saying that payments shall be made on either a salary or a capitation or a fee-for-service basis, or a combination of the three, it has been discussed at length for years behind the scenes, and it is well known that if the

Federal Government takes over the provision of care for 148,000,000 persons, it cannot possibly have the fee-for-service basis. That has been admitted by both of the main lobbying groups, by the Committee for the Nation's Health, and by the Government officials who have written this legislation. Therefore, it is stated that it would be preferable, at least at the start, to have a capitation system such as they had in Great Britain from 1911 to 1948.

A capitation system is simply this: that the doctors have a certain number of patients on the list at so much per head per year, and for a limited sum, $3.25 a year in Great Britain at the present time, they are compelled to give an unlimited service. That is the capitation system. But it has been admitted that that system is very unfair and has certain great disadvantages, and that therefore the ultimate goal should be salaried service.

Mr. Priest. Pardon me for the interruption. I wonder if it would be possible for you to summarize without reading the remainder of your statement. We are running around 45 minutes, and 15 of that was supposed to go to another witness. If you could from this point summarize the remainder of your statement, it would be greatly appreciated by the committee.

Dr. Shearon. Of course, Chairman Priest.

Mr. Priest. You may have the remainder of the statement included in the record.

(The remainder of Dr. Shearon's statement follows:)

In simple terms, the plan is this: The Government, as soon as feasible, is to take over the entire organization of medical care. During the next 2 or 3 years public hospitals and health centers are to be built. Personnel is to be trained at public expense so that the Government may force physicians, dentists, nurses, etc., who have accepted Federal fellowships to practice where the Government tells them to. A capitation or panel system is to be set up at the start with gradual conversion of the system to a salaried service. Medical care is to be be given as much as possible in public health centers under a system of group practice. The individual practitioner in private practice is to be eliminated. Patients will be expected to queue up at public centers. Their freedom of choice will be limited to those doctors in small health service areas who have agreed to become insurance practitioners. As fast as health centers are built patients will be expected to go to them. They will be permitted to choose a center, not a physician, near their homes.

Records about each person will become public records. The personal relation between physician and patient will disappear almost over night. This feature has been particularly repugnant to the women of England.

The social planners think that freedom of choice for the patient is not essential. The ILO states:

> "The right of the patient to choose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is therefore no longer compatible with the modern approach to the health problem."

Michael M. Davis of the Committee for the Nation's Health decries the fee-for-service method of payment, stating that it "is most open to abuse by patients and physicians and is the most costly to administer.

Adequate control of the services requires fiscal and professional supervision which is expensive and often vexatious. The use of the fee-for-service method should therefore be discouraged, except for specialist services under certain conditions."

The lobbyist Ernst P. Boas, M. D., has stated: "Insurance guaranteeing complete medical coverage cannot be set up, except at a prohibitive cost, if the fee-for-service principle is retained."

Isidore Falk who has written the successive compulsory health insurance bills has published a brochure entitled "Medical Care Insurance a Social Insurance Program for Personal Health Services" in which he discusses the way in which the program would be administered. He indicates repeatedly that the Government would use the capitation method or a full-time salaried service rather than the fee for service. Throughout his statement he speaks in glowing terms of the capitation method as the desirable one and even says it is the one the medical profession would probably choose. Without at this time discussing the subject further, I would point out that the capitation method of payment, that is, so much per person per year for those whose names appear on the doctor's list, is completely unfair in principle. It means the payment of a fixed sum for an unlimited service. This method would not be tolerated by organized labor in its collective bargaining, and I fail to see why the medical profession should be asked to accept this method of remuneration. But quite aside from the effect on the medical profession there is the far more important effect on patients. When a panel system of medicine is set up as it was in Great Britain in 1911, there results an entire reorganization of medical practice which is harmful to patient and physician as well as to the practice of medicine. I am certain the American people would not wish to accept panel practice as the answer to their health problems, if they understood what is contemplated.

Costs.—When it comes to the cost of the program I wish to point out that this type of legislation is invariably sold to the public and to legislators on the basis of false estimates of cost. You have been told that the program would cost 5.5 billion dollars the first year or two before it is fully operating. That estimate was made by George Soule, a member of the Committee for the Nation's Health, a man cited many times for his subversive activities and Communist-front connections. We know, however, that a program of the type promised would cost from $75 to $100 per capita and would quickly rise to $10,000,000,000 to $15,000,000,000 a year. Nor is that all. This medical care program is designed to be geared in with a program of cash sickness benefits which is always most costly. The two schemes go together inseparably in all countries having comprehensive social-security programs. Furthermore, every effort is being made to throw as many of the health programs as possible into the grants-in-aid field of finance. Thus you are being asked to pass bills for grants-in-aid for medical education, medical research, hospital and health center construction, maternal and child health services, and other special services. These are all part of the same package. That package is a national medical service controlled and operated and paid for by the Federal Government. Some of the revenue will come from a special social-security tax, some from general revenues. But all the financing will come out of the pockets of the taxpayers to the tune of possibly $15,000,000,000 a year.

The savings you are being told will result are not to be expected. Instead, Congress will have to pay for a horde of civil servants who will not be giving medical care. They will be hired to police this monstrous system which a dozen men are trying to foist on the American people. There will have to be a health-insurance staff in every governmental unit in the United States. There are 155,000 such units—States, counties, school districts, and so forth. The Bureau of the Budget estimates 5,000 additional Federal employees will be needed in Washington alone and 35,000 to 40,000 in the field. This is only the Federal policing and supervising staff. State and local staffs will be many times the 40,000 to 45,000 Federal employees. Now mind you, these people whose salaries must be paid by the taxpayers will not be giving medical care. Estimates of the number of such public employees range from 500,000 to a million. Their pay roll might run up to 1.5 to 3 billion dollars a year. And remember, they would not provide medical care. They would be clerks; statisticians; medical, dental, and nursing administrative officers; lawyers; and the usual deadwood. Yet Congressman Biemiller has stated the bill would not call for a single extra employee. The health professions themselves would be compelled to take on extra help, not to aid them in devoting more of their time to health services, but to aid in filling out Government forms.

When it comes to costs, this proposed program must be seen as part of the over-all plan for total compulsion for the entire American people. At hearings before the House Ways and Means Committee, where extension of the social-security taxing system is now under consideration, it has been pointed out that when the whole program is fully operating the costs will rise to 20 or 25 percent of pay rolls and that fully half this amount will have to come from general revenues since labor will not tolerate any great invasion of its take-home pay.

SUMMARY AND RECOMMENDATIONS

Summary.—A review of the background of this movement to nationalize medicine shows that two powerful lobbies have developed over the past 20 years—one outside the Government, headed by Michael M. Davis, the other inside the Government, headed by Isidore S. Falk. Aiding the nongovernment lobby are many Communist-front organizations, notably the International Workers Order. Davis' lobby, the Committee for the Nation's Health, draws a considerable part of its membership from Communist-front organizations. Out of 166 CNH members listed on that organization's letterhead, 91 are members or supporters of subversive organizations working to overthrow the United States Government by force and violence if need be. Whatever their methods, they are opposed to the capitalist system and to our way of life. One of their main weapons is national compulsory social insurance.

The Committee for the Nations' Health has invaded Congress. It has the ear of the President.

The program for nationalization is being sold by misrepresentation regarding the way in which it would be administered and the costs. It is a fraud on the American people.

This program is one for the socialization or nationalization of medicine. The essence of socialized or state medicine is control by the state and payment for services out of tax funds. The Federal Security Agency has tried to write a new definition stating that the program would not be socialized if the physicians were not salaried servants. That is not the issue. The issue is control and method of payment. When a National Social Insurance Board, under the direction and supervision of a Federal official, writes the rules and regulations for all the health personnel of the country, for all hospitals, pharmacists, and patients, the resulting medical care program is socialized or state medicine. Indeed, it is nationalized medicine, notwithstanding assertions to the contrary made by the President, the Committee for the Nation's Health, Ewing, Falk, and Davis.

The present bill is a first step, and a long one, toward complete nationalization of medicine. The ILO itself stated:

> The fact is that once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. *The next step to a single national medical service is a short one* * * * [Italics mine.]

Recommendations.—This committee has a solemn obligation to the people to find out what is back of this whole agitation. I therefore recommend:

1. A thorough investigation of the Committee for the Nation's Health, the Physicians Forum, and the Communist-front organizations from which they have drawn a considerable portion of their membership. The investigation should also cover the Federal lobby, including especially the activities of the Federal leader, Isidore S. Falk, his collaborators, Wilbur J. Cohen, and George St. John Perrott, and his backers, Arthur J. Altmeyer and Oscar R. Ewing, latest addition to the front for nationalization of medicine. The operations of the private-Federal lobby, the Committee for the Nation's Health, Inc., should be investigated at the same time. The whole question of the financing of these lobbies should be gone into, since there is every reason to believe these are the most dangerous, insidious, and well heeled of all the lobbies in the United States. They penetrate the press and the radio; they use minorities, especially groups of foreign born with alien ideologies; they collaborate with, and seek the support of, Communist-front organizations. They have the ear of the President and of Members of Congress.

2. Creation of a Federal commission, similar to the Hoover Commission, to study the Nation's health problems and needs. There should be a special provision excluding from top posts and from staff jobs all persons employed by the Federal Government.

3. An urgent request to Attorney General Tom Clark to prosecute the 46 Federal employees who were accused in 1947 by the Harness subcommittee of the House Committee on Expenditures of lobbying for the Wagner-Murray-Dingell bill. The FBI spent 4 months making its investigation. The Justice Department has had the FBI

report since late in 1947 but has not moved to prosecute the officials who were accused of lobbying. Instead, that Department has instituted suits against physicians and at least one State medical society in an obvious effort to bedevil the medical profession. The public should be informed what is back of Tom Clark's inaction on the one hand and hyperactivity on the other.

4. A thorough investigation of the Federal lobby National Health Assembly, Inc., and of Oscar R. Ewing's lobbying for the nationalization of medicine.

5. That the committee refrain from reporting favorably on this omnibus bill for national compulsion, H. R. 4312, until recommendations 1, 2, 3, and 4 have been carried out.

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Dr. SHEARON. The point is this: I suppose this is the most important legislative proposal that has ever been presented to the Congress of the United States. It would strike into every family. It would lead to the change of our form of government, many people believe. Therefore, I think it should have the fullest discussion. And, after all, Representative Dingell did take 2 hours, and I am an expert in this field, and I am presenting information that I trust will be of service to the committee.

However, I shall leave out the rest of the statement if you like, and I will summarize it.

I might say this: Mr. Falk has printed a brochure, which was printed for the Senate committee in Senate Committee Print 5, in 1946, on Medical Care and Insurance, 186 pages long, and he really tells how the thing would be administered. It is a book that everybody ought to read. It is very dull, dry reading, and you probably won't read it, but it really gives you some idea of what they have up their sleeves in regard to the administration. It is nothing like what you think it would be by merely reading the bill, and I suggest that the committee staff might find it a very valuable document.

The costs have been represented to be about 5½ billions at the start for the first year or two. Well, that might be a fair estimate. The system wouldn't be in operation and the population wouldn't be covered, and 5½ billions might do it. We know perfectly well that when the entire population is covered, if we take a per capita cost for complete medical care, dental, nursing, hospital care, and so forth, estimates have been made very carefully by people who have no interest in making them one way or the other, and the cost could run from $70 to $100 per capita, and that would probably run it up to 14 or 15 billions a year. We had one man in the Senate recently who was in favor of the bill who said that it might be 18 billions a year. You have to, therefore, think of that, and think of that charge upon the family income.

Some people, of course, would rather spend their money in some other way, since a large amount of money would go not, of course, to medical care, but to the support of the policing system that would be set up. In regard to that, Congressman Biemiller, I think I heard you say on the radio that it would not take one other additional person in the Federal Government to administer the scheme.

Mr. Biemiller. Mr. Chairman, I want to inject something right here. This statement is typical of most of the statements in this document. I said no such thing. What I said on the air was that in my opinion it would not take any additional personnel to collect the payroll taxes, because they would be collected in exactly the same manner as are the present social-security taxes. I have testified here in front of this committee that I believe it would take about 50,000 people.

I submit that this half-truth is typical of the entire statement of the witness.

Dr. Shearon. The Bureau of the Budget said, I think, that it would take—and I say this from memory, so I can't be accurate about it—about 6,000 additional persons to collect the taxes alone. That, of course, would not be giving any medical care. I wish to point out that there are 155,000 governmental units, States, counties, school districts, and so forth. There would unquestionably have to be some sort of a set-up in each of these units to carry out that scheme. With 155,000 units, if you allowed for 5 persons in each unit, which would be very small—and, of course, in the large cities it would be a very much larger number—you could see that it would run up easily to from three-quarters of a million to a million persons. Nobody knows how many. But you do know that if you have this sort of a system, which has to be policed by government and has to be run on a 24-hour basis to meet emergency conditions in regard to medical care, you would have to have some staff if you just had one physician and one dentist and one secretary.

Well, I leave it to your imagination, but it is obvious that it would take an enormous number of persons. No one can give an accurate estimate in advance.

You have been told that savings would result. I submit that when a large part of the money must go not to giving medical care, but simply to policing the system, which is the thing that has been expensive in the countries of Europe that have tried it, then the people are not getting more and better medical care for their money. They are being required to pay large sums to keep up a large bureaucratic set-up.

And the policing, I might say, is something that has been written up quite thoroughly. There are volumes and volumes on the subject of the administration of these health-insurance programs throughout the world. It takes literally shelves in the libraries to cover the material on this subject. They have to have statistics on the physicians, the dentists, the pharmacists, the persons who give appliances in the hospitals. They compare what doctors do, one doctor with another doctor on the block, and so forth, to see if they are keeping within the limits. And the amount of policing is simply beyond belief.

That, of course, does not show up in any way in the bill, which simply says that the Administrator is hereby authorized to write rules and regulations.

Now, in summarizing, I would bring out this fact: that there are these lobbies that have been working actively for the past 25 years. The two main ones outside the Government are the Committee for the Nation's Health—which has grown considerably more powerful and has more money, now about $160,000 a year to spend, and an additional staff—and the Physicians Forum, which is headed up by Ernst P. Boas, M. D., who is or has been a member of eight Communist-front organizations.

Mr. Sadowski. Are you a doctor of medicine?

Dr. Shearon. No; I am a Ph. D. I am trained in pure science. I received a Ph. D. at Columbia in 1916.

Mr. Sadowski. Oh, you are not a doctor of medicine.

Dr. Shearon. No, no. I am a legislative consultant and a writer, editor, and publisher. I have made a study of this thing. I am regarded by some people as one of the experts in the country in the field. I had my training in the best place in this country to get it; namely, in the Social Security Administration. Those were the finest files, I suppose, in the world, and I was exposed to the greatest amount of information on this subject, on the matter of the rules and the administration for the plans that are to be written, and so on. The only reason that I and all of my colleagues have left the Federal Government is because we didn't want to be a part of this sort of thing.

Mr. Sadowski. You have made some very strong allegations here against individuals and various organizations, charging them with being lobbyists for this bill. Are you a registered lobbyist?

Dr. Shearon. Yes; I am. I registered under protest. I am an editor. I publish a weekly paper. And editors, I think, are not ordinarily compelled to register. I did so register.

Mr. Sadowski. What compensation do you show as receiving for your lobby work?

Dr. Shearon. I have no compensation. I am not in anybody's pay. I am an independent. I was simply so disturbed about this whole situation that I left the Federal Government in 1945 at a time when it was not advantageous to me to do so.

Mr. Sadowski. You have handed to the committee, or at least I have received here from you, seven documents.

Dr. Shearon. That is correct.

Mr. Sadowski. One is American Medicine and the Political Scene.

Dr. Shearon. That is my weekly paper.

Mr. Sadowski. Another is Socialized Medicine—Regulative Interference Under the W-M-D-Bills. Another is Specialized Medicine—Bureaucratic Control of Medicine. Another, Socialized Medicine—New Zealand's Free Medical Benefits. Another, Blueprint for the Nationalization of Medicine. Another, National Compulsory Social

Security Medicine. And then this long document that you have read from.

Now, have you printed and published other documents besides these?

Dr. Shearon. No. Well, I did when I was in the Government; yes, but that was before I left the Federal Government. I published various papers.

Mr. Sadowski. These are beautiful-looking documents. They are highly colored. This one is orange, and this one in violet, and these in some other colors. And they cost money.

Dr. Shearon. That is right.

Mr. Sadowski. These kinds of documents cost money to print. How did you get this money to print these documents?

Dr. Shearon. As I told you, when I left the Senate committee on July 1, 1947, I set up my little business to print my little paper, and we used our savings, my husband and I. We have no staff. We have no office. We did set up an office and we couldn't afford to keep it, and I had a secretary and I couldn't afford to keep her.

Mr. Sadowski. You have paid for all of this out of the savings of your husband and yourself, you say?

Dr. Shearon. No; not all of it. I have paid part of it. The rest has come from the sale of those documents. I sell those for 25 cents apiece, four or five of them. And I might say there are two others of that series. I didn't bring them, because I thought you wouldn't be particularly interested.

Mr. Sadowski. Who buys these documents from you?

Dr. Shearon. Well, they are bought all over the country by libraries, study groups, business groups, insurance companies, medical societies, dental societies, hospitals, Blue Cross plans, and, of course, a great many by just individuals. They write in and buy them. People have bought them from all over the United States. It is a very wide distribution. I don't advertise. I don't have the money to advertise.

Mr. Sadowski. How many of these documents have you sold?

Dr. Shearon. Thirty thousand of those, of the Socialized Medicine and the Blueprint.

Mr. Priest. Have you finished your statement?

Dr. Shearon. I did want to complete this summary.

I have four recommendations that I should like to make. The first is that there should be a thorough investigation of the Committee for the Nation's Health, the Physicians Forum, and the Communist-front organizations from which these lobbies have drawn a considerable portion of their membership. I also suggest that that investigation should also cover the Federal lobby. If my statement is not going to be printed——

Mr. Priest. Your statement will be printed in the record.

Dr. Shearon. I would suggest the establishment of a Federal commission, similar to the Hoover Commission, to study the Nation's health problems and needs.

Third, I recommend an urgent request to Attorney General Tom Clark to prosecute the 46 Federal employees who were accused in 1947 by the Harness subcommittee of the House Committee on Expenditures of lobbying activities for the Wagner-Murray-Dingell bill.

Now, I was making the recommendation of the investigation of these two outside lobbies, and at the same time that the Government lobby be investigated. I referred to this document. I will not leave it, but I wish to show it to the committee.

This is a document that was written partly, at least, by the Committee for the Nation's Health, for the Communist IWO, and they got their help from Federal employees. The only references that are given are to the works of the lobbyists. It was distributed through the IWO. It is called Medical Insurance, a Pathway to Health.

I think a document like this is of extreme importance to the American people. I think that the members of the committee should at least look at it. And the fact that the Federal Security Agency supplied photos, and so forth, for this Communist organization for a propaganda film script should be considered. It is because of these things that I think it is important that the Congress look into the interrelationship between the outside lobbies and the Government lobbies, the Government lobbies being supported by tax funds.

I then suggested that there be created a Federal commission similar to the Hoover Commission to study the Nation's health problems and needs and that, if such a commission is formed, nobody from the Government should be permitted to occupy the top posts or staffs.

The third recommendation is for an urgent request to Attorney General Tom Clark to prosecute the 46 Federal employees who were accused in 1947, unanimously, by the Harness subcommittee of the House Committee on Expenditures of lobbying for the Wagner-Murray-Dingell bill. The FBI spent 4 months making its investigation of those Federal employees. The Justice Department has had the FBI report since late in 1947 but has not moved to prosecute the officials who were accused of lobbying and of breaking Federal laws. Instead, that Department has instituted suits against physicians and at least one State medical society in an obvious effort to bedevil the medical profession. Those suits were instituted 2 days before the election last year, but Clark already had this other case on file in his Department, and one wonders why he gave the priority to the suits against the physicians.

The fourth recommendation is that there should be a thorough investigation of the Federal lobby National Health Assembly, Inc., and of Oscar R. Ewing's lobbying for the nationalization of medicine.

And the fifth recommendation is that the committee refrain from reporting favorably on this omnibus bill for national compulsion, H. R. 4312, until recommendations 1, 2, 3, and 4 have been carried out.

That completes my statement.

Mr. Sadowski. Any questions? Mr. Wilson?

Mr. Wilson. Doctor, I am not concerned personally about any attack on any individual or anything of that nature that has gone on here this morning. Why is it that you are opposed to this, as a person who has studied it? Tell me briefly your particular reasons why you are opposed to compulsory health insurance?

Dr. Shearon. It was what I saw from a very careful study. I spent three and a half years with the Social Security Board, and a large part of that time was spent studying the thing. I wrote the first draft of the original provisions of the first Wagner bill for 1939. That was a very simple bill, now, just a grant-in-aid bill.

Mr. Wilson. While you were on the Senate committee staff?

Dr. Shearon. Oh, no. That was before.

Mr. Wilson. That was while you were at the Social Security Board?

Dr. Shearon. At Social Security, yes. That was back in '39. I saw what the plan was, and so did my fellow workers. We all saw what the plan was. We studied the administration in other countries, what it does to the patients, the physicians, and dentists, and the health personnel, and what it eventually leads to in terms of the change in government in the countries that institute this type of system. It is a part of state socialism. It was regarded as the high-water mark of state socialism in Germany back in the thirties. It is a Socialist program.

Now, if you happen to believe in state socialism, you think it is good. If you think that everybody ought to be controlled by the state and look to the state, then you think it is good. If you think otherwise, then you don't think it is good.

I couldn't see anything that had come out in any other country in the operation of these programs that led to any good for the country, but it did lead to the deterioration of medical care, to the ruination of the medical profession. It did not improve health. And, as was said, for instance, in Germany, the health funds were one of the main supports for Hitler when he took over Germany. It was a great temptation, this building up of large funds in the government, as was shown in the case of the old-age-insurance trust fund.

Seeing these things, I left Social Security and I got a transfer to Dr. Parran's staff. I admired him greatly, and I thought there was a big job to do in the health field. I was there for nearly 4 years. Dr. Parran, as you know, is a fine public-health official. I think he was highly respected by the Members of Congress on both sides, Republicans and Democrats. He has had long experience and training, and was a good public-health man. He did not believe in compulsory insurance. And in 1944, when they were stirring all this up for the new Wagner-Murray-Dingell bill, he was told to get on the bandwagon. He tried to get on, and didn't succeed very well. I said, "Dr. Parran, you don't believe in this. What does it mean when people who are not medical people are laying down the plans and making the legislative proposals in this country?"

And all these top people are not medical people, with the exception of Dr. Boas. I said, "It's very peculiar. The Health Service people are not the ones planning the health of the country." And Dr. Parran said, "If the Administrator says it has got to be compulsory health insurance, it has got to be." And we split on that.

Mr. Sadowski. It is now after 12 o'clock, and we have another witness we would like to hear before we adjourn.

Mr. Wilson. One more question, Mr. Chairman.

Your answer to me, Doctor, is that you are opposed to the word "compulsion." Is that it? Based on your study of what is done in other countries?

Dr. Shearon. I am opposed to the compulsion, what it leads to. It doesn't lead to good medicine. It doesn't redistribute doctors. It doesn't do the things that the people who are propagandizing for it say it will do. It is just a delusion and a snare.

Mr. Wilson. That is all.

Mr. O'Hara. Mr. Chairman, I would like to ask a question.

Mr. Sadowski. Mr. O'Hara.

Mr. O'Hara. Dr. Shearon, someone laid on my desk this morning Nation's Health, a Ten-Year Program. Is that one of your publications?

Dr. Shearon. No; I should say not. That is Oscar Ewing's. Sixty thousand of those have been printed at Government expense, so far, according to a letter I have in my bag from Donald Kingsley. It is a streamlined book, with some truth in it, and a great many untruths. It is being sent all over the country whether people ask for it or not.

Mr. O'Hara. Do you endorse it?

Dr. Shearon. I do not.

Mr. O'Hara. That is all, Mr. Chairman.

Mr. Sadowski. At that point, I ought to read the rest of the cover of this pamphlet Mr. O'Hara referred to: "Nation's Health; a Ten-Year Program; a Report to the President by Oscar R. Ewing, Federal Security Administrator."

So this book here, or this pamphlet here, was published at the request of the President, I assume. It is not a book of propaganda. The President made a request to the Federal Security Administrator to give him a report as to the Nation's health. This book is in response to the request made by the President of the United States.

Mr. O'Hara. Mr. Chairman, on the last page, on page 186, it says:

> For sale by the Superintendent of Documents, U. S. Government Printing Office, Price $1.

Mr. Sadowski. As are many other Government documents for sale and may be purchased from the Government.

Mr. Wilson. The letter of transmittal, printed in the front of this document, is addressed by the Federal Security Administrator to the President, and starts:

> In accordance with your request of January 30.

Mr. Sadowski. That is correct.

Dr. Shearon. Donald Kingsley testified in the Senate hearings that the letter had been written in the Federal Security Agency for the President's signature. It is issued from the Federal Security Agency, to have this national health assembly.

Mr. Biemiller. I will not stress this, although I wish I had time to do it. The various inferences that have been made about the Committee for the Nation's Health I think are most unjust. The witness is not referring to the current letterhead. She is referring to a letterhead of many years ago. On the current letterhead there are such notorious "Communists" as Gen. William J. Donovan, who was head of OSS during the war, a prominent New York Republican; Newbold Morris, a Republican who was head of the New York City Council under LaGuardia, another Republican; Matthew Woll, who has been very prominent in his opposition to communism during the years; and people of like mind. Another one is Mrs. Gardner Cowles, for example.

Mr. O'Hara. Mr. Biemiller, you do not mean to leave in the record the thought that you claim that Mr. Donovan and these other people are Communists.

Mr. Biemiller. No. But the witness claims the Committee for the Nation's Health was infiltrated.

There is just one other point I wanted to make, and I think it is a very interesting one. One of the people to whom the witness referred was Dr. Boas. I think Dr. Boas has been most indiscreet as to some of the organizations of which he has been a member. I would not be a member of them. But I do want to show to the committee the extremes to which you can go in this guilt-by-association idea. I have in my hands a copy of the Journal of the American Medical Association for the 4th of June, the most recent issue.

On page 481, under Organization Section: "Official notes: Establish national commission on chronic illness." The article goes on to say how the AMA has been active in its formation, is giving office space to this commission, is also supplying the funds for the commission to operate—a very worthy enterprise. I am very glad that this is being set up. And then it goes on to say that the chairmen for these group meetings included Dr. Boas, of New York and certain other individuals.

Now, if you are going to say that because Dr. Boas once associated with the Abraham Lincoln Brigade, and therefore the Committee for the Nation's Health is suspected of having too many Communists and Communist sympathizers in it, evidently the American Medical Association is getting into the same position. I simply cite that as an illustration of how absurd this procedure can be.

Mr. SADOWSKI. Any further questions? If not, we thank you, Dr. Shearon and we shall proceed with the next witness.

Our next witness is Mr. A. J. Hayes. State your full name, your address, and the organization you represent, Mr. Hayes.

STATEMENT OF A. J. HAYES, PRESIDENT-ELECT, INTERNATIONAL ASSOCIATION OF MACHINISTS, WASHINGTON, D. C.

Mr. HAYES. My name is A. J. Hayes. I am general vice president of the International Association of Machinists. My address is Machinists Building, Washington, D. C.

Mr. Chairman and members of the committee, the International Association of Machinists appreciates this opportunity to appear in support of and endorsement for those bills now before this committee. I want to state for the record that the International Association of Machinists is a labor organization; that we are opposed to Communists and communism in any form; and we still favor these bills. We believe that the guarding of the health of the Nation and the curing of the sick is just as important as protecting the well against contagious diseases and accidents and death.

We ask enactment of these identical bills, because they will provide a means by which the people of this country can be assured of enough medical services to meet their needs.

The plain people of this country have advocated the principles of these bills for a long time. Our Government itself has been a pioneer among nations in the field of health insurance against the costs of medical care. As far back as 1798, our Congress enacted a law requiring all merchant seamen to contribute a certain monthly amount for the building and maintenance of marine hospitals. The first hospital was erected at Norfolk, Va., in 1890, and merchant seamen have received care in them ever since that date. The idea of health insurance as proposed in these bills is no more foreign to our democratic system than is a mutual insurance company, our school systems, or our Social Security Act.

For the past 50 years people in this country have experimented with various ways of insuring themselves against the costs of medical care.

The need for a health-insurance and public-health act certainly cannot be challenged by any person or group who are sincerely interested in the general health and welfare of the plain people of this country. Facts which we were able to gather show that even during the war year of 1944, with full employment enjoyed by every person able to work, 81 percent of the American people could not afford the medical care they needed.

In 1945, 40 percent of the people questioned by the National Physicians Committee said that they knew people who had gone without doctor or hospital care because they could not afford it. Even here in the Nation's Capital nearly one out of every five residents reported that they put off going to a doctor because of the expense. A study by the Bureau of Economics of the American Medical Association in 1939 showed that families within incomes below $3,000 could not meet the cost of serious illness without assistance or charity. Considering the rise in living costs since that date, we find that families with incomes of $5,000 today are facing the same problem. This means that today four out of every five families are seriously threatened by the misfortune of serious illness. To 80 percent of our people this threat means loss of savings and mortgaged futures. This situation poses a threat to our entire national economy. Unfortunately present methods of paying for medical care through voluntary health-insurance plans cannot meet and have not met our needs.

Because of the economic position of our families and other restrictions imposed by selfish interests, only 3½ million Americans are today covered by comprehensive medical-service plans.

It is not only from the economic standpoint that our national health picture is weak. We need more doctors, nurses, dentists, hospitals, and technicians. Our weakness in doctors alone is forcibly brought home by the fact that in our cities there is only 1 doctor to every 500 persons, and in rural areas only 1 doctor to 1,700 persons. This explains in part why only 1 out of every 10 southern mothers receive the needed care in childbirth. It also helps to explain why 50 to 100 babies out of every 1,000 in 4 of our States die in their first year. The deficiency in our present health agencies, voluntary health plans, and State programs convinces us that only through a comprehensive insurance and health act as proposed by this legislation can adequate medical care be brought within the reach of our deserving people.

It is also for this reason that we cannot endorse plans, programs, or legislation which are aimed at relieving only one part or segment of our health needs. These piecemeal, patchwork proposals will at best only give relief to instant conditions, and ultimately work a fraud on the millions of people now looking to a solution of their health problems.

We recognize that health cannot be legislated. We also acknowledge that a sound program for good medical and hospital care cannot be achieved by waving a magic wand. It is this same realization which convinces us that only a national program enacted by the Federal Government can guarantee the essentials necessary to meet the full requirements to a successful program. The enabling legislation must be comprehensive and yet retain the principles of our American democracy. In keeping with American tradition and belief, it must require certain obligations from its beneficiaries, and at the same time confirm their conviction in our legislative processes.

Specifically, the enabling legislation must provide more doctors, dentists, nurses, technicians, and allied personnel. It must recognize the need for research which is necessary to discover the causes, cures, and preventives of diseases that take a heavy toll of lives. It should include clinics and ambulance services, together with the component personnel and facilities for rural and other shortage areas. State and local health services should be expended, should also guarantee additional services for maternal and child-health care, and last but far from least in importance, should provide a means with which to pay for the health and medical care necessary to assure and maintain a healthy people.

Basically, the enabling legislation to improve our Nation's health must contain coverage that is Nation-wide in scope. It must be comprehensive enough to pay for almost all medical services needed by the average family. It must provide for sound administration, administered in the public interest. Professional freedom must be guaranteed, so that high-quality care and better standards can be encouraged.

From our analysis of the bills now before this committee for consideration, we believe their enactment would meet these purposes and needs. Without going into detail on the 163-page bills, I do wish to make some general observations with reference to each title.

Title 1 provides for the authorization of Federal aid for the education and training of professional health personnel. This will be carried out by the expansion and improvement of existing schools, together with the construction and equipment of new schools. State scholarships are awarded to provide a means and incentive to increase enrollment in schools of medicine, dentistry, dental hygiene, nursing, public health, and engineering. This title recognizes a need in which we have long been woefully weak. In fact, many people are today denied treatment when they most need it, because of the shortages which exist in the medical profession. Reliable sources report that our medical personnel number only about 80 percent of what is actually needed. To correct this situation, it will be necessary to enroll and train within the next 10 years a total of 15,000 doctors, 5,000 more dentists, and 40,000 more nurses, together with the necessary technicians. This requirement is over and above the expected production of such medical persons with present facilities.

Title 2 gives the United States Public Health Service authority to establish additional institutes now vitally needed for research of those devastating diseases, such as diabetes, arthritis, and others which daily take their toll of our people in suffering and in death. It gives to the Surgeon General the special advisory councils so necessary in this technical field.

Title 3 modernizes and put a sound foundation under our need for more and better hospitals. By expanding the present appropriation of $75,000,000 to $150,000,000, we can go a long way in meeting the urgent need for 900,000 more hospital beds. A condition which shows that 15 percent of our present non-Federal beds are in buildings which do not meet established standards and crowded conditions which make many hospitals virtual firetraps certainly cannot go unheeded. Persons making a study of our hospital conditions report that it will cost at least $5,000,000,000 to realize just half of our needs in the next 10 years. This title also recognizes a basic need in our general health program by providing grants-in-aid so that the poorer States may obtain up to two-thirds Federal contribution, instead of the flat one-third which is presently provided.

Titles 4, 5, and 6, which provide for special aid for rural and shortage areas, expand the present law for grants-in-aid for State and local health work, and for maternal, child-health, and crippled children's services, have previously been covered. I do not believe it is necessary to elaborate on them at this time.

Considering the final section, section 7, we come to that title which to us is the very heart of this legislation. Careful study and recognizing the needs of our own over 600,000 members and their families convince us that the solution to medical care is a Federal system of prepaid personal health insurance. Our conviction is not alone based on technical and scientific charts or figures. To a great extent it comes from first-hand knowledge that our families live under a constant fear of costly medical expenses which they cannot guard against under present conditions. This same fear used to apply to old-age and unemployment, but our Government has recognized this need, and today, while inadequate, we do have a functioning system which has been accepted and endorsed by all working people which, to a certain extent relieves those fears.

The reason we keep stressing the working plain people of this country is because they represent the bulk of our people who are the victims of our present inadequate health system. The well-to-do and the charity patients are, for the most part, adequately cared for. Present voluntary plans at best can only supply a small part of the in-between group with partial financial support. The dollar barrier to good adequate health care must be lifted from these people. That is why we endorse a system of health insurance as set forth in title 7 of these bills. It provides health insurance which is national in scope and would cover approximately 85 percent of the entire population, including employees and self-employed persons in business for themselves, as well as their dependents. This coverage would entitle them to medical and dental service from general practitioners and specialists, supplemented by home nursing care, hospital care, laboratory service, expensive prescribed medicines, X-rays, eyeglasses, and special appliances.

This is accomplished, in our opinion, in true democratic fashion. It preserves the dignity of the individual and makes him an interested stockholder in his Government. The provisions in these bills refute totalitarian ideologies by explicitly providing for the free choice and change of doctor and dentist by the patient.

This also applies to the professional. Every doctor, dentist, nurse, and hospital is reserved the right to participate or not, as they choose. They are guaranteed the right to accept or reject patients. Freedom from governmental supervision and control is likewise given to every hospital, clinic, and health group. Even the payments to doctors to cover services rendered are made flexible by leaving the method of payment to the decision of the doctors practicing in that area.

Administration of the program also recognizes our true democratic system by placing major responsibilities in the hands of the people in localities where the services are rendered and received. Each State is given the right to administer the system through its own State agency, divided into local areas. This leaves medical matters in the hands of professionals, where it rightfully belongs. The consumer who pays the bills has a voice in such matters as administrative details, scope of benefits, eligibility of membership, fees et cerera. On the over-all level, a five-man board under Federal administration, assisted by an advisory council of both professional and lay people, will lend their guidance and administrative assistance to the State agencies.

In conclusion, we are firmly convinced that the enactment of H. R. 4312 and H. R. 4313 would be of great service to the country as a whole. It will make possible a system of just medical care to all on the basis of need, and not on the basis of the size of their pocketbook. It will assure good-quality care for all Americans, regardless of race, creed, or economic circumstances. The United States is one of the few industrial Nations in the world that does not have a system of prepayment for medical care as a part of its social-insurance system.

While this in itself does not prove a case for or against health insurance, it is significant that no country has ever repealed such a system once it has been established. Today the United States is looked upon for guidance and leadership by all the democratic peoples of the world. We have accepted this role. In order to justify this position, we must show ingenuity and courage. Certainly we are faced with the fact that each year 325,000 people who whom we have the knowledge and skill to save, it is evident that here lies one problem that that not justify our rightful claim of leadership.

There is ample proof that the overwhelming majority of American people support a national health-insurance plan. This is attested to by the fact that a poll conducted by the Washington Post in January 1946 showed that a majority of 70 percent of the people in the District of Columbia favored the enactment of a Federal health-insurance program. We are all aware that a drain of $27,000,000,000 from our Nation every year through sickness and disability can and will affect our long-range economy. This is also true of the Nation's yearly loss of 4,300,000 man-years of work through bad health. We must assume the responsibility to do our utmost to insure that all people in this country, and not only a chosen few, attain the highest level of health care. It is for this reason that we ask for the speedy enactment of legislation proposed in these bills which in our opinion will adequately accomplish these results.

Mr. Sadowski. Thank you very much.

Mr. Biemiller. I would simply like to observe for the record that the great State of Wisconsin is very proud of her native son, Mr. Hayes, who has recently been elected president of the International Association of Machinists. He enjoys a fine reputation in our State, having the respect not only of labor but of the business and professional people in our State. I find myself in very substantial agreement with his statement and am pleased that he was here to present it.

Mr. Sadowski. Mr. Wilson?

Mr. WILSON. Mr. Chairman, on the witness's statement, on page 6, I read this sentence:

> The dollar barrier to good adequate health care must be lifted for these people.

Referring to the bulk of our Nation, the working people.

I am interested and would like to know a little bit more about your comments on the dollar barrier to good health care.

Mr. HAYES. Congressman Wilson, we know from our experience as representatives of the plain people, those who join labor unions, and we know from our experiences in our own families, if you please, that adequate health is not being provided for a large percentage of the plain people, because they do not now have the dollars with which to buy that health. They are not in a position to give adequate care to themselves, because they do not have the money to pay the doctors.

There are many instances that we know of where mothers and fathers have neglected their own health, because they were sending their children through college, or because they had a large family to support, and could not afford to take care of their own health. We think those are the dollar barriers, and we know that there are hundreds of thousands—and probably that amount is not adequate—of people who are in that position today, who need medical care, who need it badly, and who cannot afford to buy it.

Mr. WILSON. Is it not a fact that a great percent of the cost of medical care when a serious illness comes is not only bound up in the doctor's bill but also in the hospital bill? Maybe even more in the hospital bill than the doctor bill.

Mr. HAYES. Yes, very definitely.

Mr. WILSON. That is all, Mr. Chairman.

Mr. SADOWSKI. If there are no further questions, we thank you, Mr. Hayes.

Mr. HAYES. Thank you.

Mr. SADOWSKI. Mr. Carey, we will hear you now.

Give your full name, your address, and the organization you represent.

STATEMENT OF JAMES B. CAREY, SECRETARY-TREASURER, CONGRESS OF INDUSTRIAL ORGANIZATIONS, WASHINGTON, D. C.

Mr. CAREY. Mr. Chairman and members of the committee, I am James B. Carey. I am appearing on behalf of the Congress of Industrial Organizations, of which I am secretary-treasurer. I also serve as chairman of the CIO's committee on health, safety, and welfare.

American workers want first-rate medical care at a reasonable cost. They want help in keeping well, prompt and good care if symptons develop, and comprehensive insurance against the cost of medical expenses, both in short and long periods of illness.

That is why the CIO supports H. R. 4312, the bill to improve health services and to launch a national program of health insurance. Our members' desire for this bill has been demonstrated both through official resolutions and through numerous meetings at which the need for health legislation has been thrashed out.

For years Congress has had a health insurance bill before it. But it is still in the hearing stage. We are fed up with all the discussion about States' rights and such discussions that forget the rights of the people to decent health standards.

We are awfully tired of the use of so-called voluntary plans and State plans as a means to delay providing decent health opportunities. Do the advocates of these proposals think the people can be kidded or satisfied by these excuses for not passing a decent bill?

American medicine has made marvelous strides in the last 50 years. Some of its benefits, such as diphtheria inoculations and the sulfa drugs, have been made widely available. But the expensive methods of examination and diagnosis utilized in difficult cases are still largely the privilege of the higher-income groups, or cost so much that the average worker either incurs terrific bills or must receive help through proving he cannot meet the expense.

Industrial and agricultural production have likewise made tremendous strides so that Americans are producing far more than ever before. They want their higher standard of living to include good medical care just as it includes a decent home, good food, movies and, if possible, an automobile.

Americans naturally turn to their Government to provide essential health services and insurance against the costs of medical care. More than a century ago they carried on a similar fight for public education against the opposition of those who thought that workingmen's children didn't deserve it. Fourteen years ago we secured passage of a national program of old-age insurance, which has thoroughly proved its value, although it needs to be extended and improved.

American workers know that the Nation and their own earnings can support good medical care if the Government promotes expansion of facilities and helps the people to pool the risk, contributing some funds from general revenues. Our members are indignant at the continuing delay in enacting such a program.

The demand from the people has been so great that the American Medical Association and other conservative groups have tried to develop substitutes, which are not satisfactory. These substitutes in part take the form of voluntary organizations, such as Blue Cross and Blue Shield, to which groups can belong and secure a limited amount of protection against the cost of hospitalization, surgical services, and sometimes other types of medical care.

The people also have been offered help through legislation on a charity basis, with the Federal Government giving funds to the States to help the lowest-income groups on the basis of the means or income test. More recently the two types of inadequate substitutes have been combined in proposals that would give Federal funds to the States, not only to help the lowest-income groups, but to promote the growth of the voluntary associations, with the Federal Government paying part of the cost for the middle-income groups.

The people don't want horse and buggy medical care nor horse and buggy health bills. They want the genuine article, national health insurance.

Only through a national insurance program can all Americans get protection against the cost of preventive medical care and exceptional expenses. Only through such a program can middle-income as well as low-income groups be assured that their wages will not suddenly be drained away and huge debts piled up because of sudden illness.

Only through a single law, affecting all States alike, can our people have available an efficient, low-cost method of financing.

The typical worker has trouble budgeting his family expenses even when he is well. The minimum adequacy budget of the United States Bureau of Labor Statistics indicates that in the typical large city at least $65 a week is necessary to provide healthful living and normal social participation for a family of four. That $65 a week is on the assumption that a pay check of that size comes in every week all through the year, year after year. Nothing is allowed for savings except a small sum for life insurance. The level is minimum indeed.

Millions of American workers who are heads of families earn less than the necessary amount. For example, the Bureau of Old Age and Survivors Insurance estimates that in the relatively good year of 1948 only one out of five covered workers with wages recorded in all four quarters of the year had total annual earnings of $3,600 or more, one out of eight received between $3,000 and $3,600, and two out of five between $1,800 and $3,000.

What happens then if illness strikes? The worker goes to his doctor—and we will assume he knows a good one, though this is unfortunately by no means always true. Perhaps the doctor suspects a gastric ulcer or cancer, but an X-ray alone would probably cost $50. The doctor knows that the worker cannot afford this amount, and a large X-ray bill may interfere with the payment of the doctor's own account. Too often the physician lets things ride. The worker may develop an acute condition that could have been prevented.

Or suppose the general practitioner suspects the presence of a gall bladder condition and wishes to call in a specially qualified surgeon. The consultation alone, including laboratory work, may cost between $50 and $150, including a day or two in the hospital. With such financial barriers influencing both the doctor and the patient, the latter cannot enjoy that close relationship with his physician which the American Medical Association seems to think would be imperiled by health insurance. On the contrary, only through removal of financial barriers can a proper bond be established.

Even if the chief wage earner escapes illness, children are apt to run up bills for common diseases such as measles, mumps, or influenza. The mother is torn between adding to debts and calling the doctor for another visit.

Extremely serious cases occur especially among older people. Last week Mrs. Anna Hilton appeared for the CIO before the Senate Subcommittee on Health and told her tragic case. Appendicitis, followed by generalized peritonitis, kept Mr. Hilton in the hospital for 8 months. The hospital bill alone totaled over $4,500 and doctors bills and prescriptions an additional $770.

Although Senator Taft, in commenting on Mrs. Hilton's testimony, assumed that only one person in 40 is affected by such catastrophic illness, actually a far larger number of families are severely affected at some time or other. According to a public health report, out of every 1,000 persons who are well at age 45 about 100 will require, during the next 5 years, medical care for a chronic disease or major impairment. Some of these 100 will then require periodic medical treatment, and a few of them will need almost constant medical care of some nature until they die. Nearly one-fourth of the people who are well at age 60 will develop a chronic ailment during the ensuing 5 years for which they will seek or require medical treatment, and in many cases continuing care.

Untold thousands of persons are actually suffering from diseases that require treatment, but low incomes or lack of education lead them to utilize ineffective home remedies.

Private insurance companies do not offer a way out for American workers. Most of the group plans of the insurance companies pay back to subscribers not more than 70 cents out of each $1 paid in. More than 30 percent normally goes for administrative expenses, reserves and profits.

The Blue Shield medical-care plans sponsored by the medical societies have an administrative cost of 17 percent on the average. Most of these plans moreover cover only surgical services, sometimes only in the hospital, and do not cover the expenses of going to the family physician for preventive treatment or simple illness. The American Medical Association, which allegedly speaks in the name of the family physician, excludes his home and office care from these programs and fights national legislation that would increase both his usefulness and his income.

If the Hiltons had belonged to the medical-surgical plan of the Blue Shield in New Jersey, they could have received medical care only while Mr. Hilton was hospitalized and then only for 21 days. Since their income had been over $3,000 a year, the Blue Shield would have paid only certain minimum fees and the doctors could have charged much more. As Mrs. Hilton explained, the family did carry Blue Cross hospital insurance at $30 a year, but this covered hospitalization for 1 month only.

Clearly these voluntary plans could not meet the needs of the Hiltons nor of families far less seriously affected.

The CIO is made up of voluntary organizations itself, and we favor the voluntary banding together of workers to achieve desirable goals. Many of our organizations have secured and are now seeking agreements providing protection against the costs of sickness, medical care, and hospitalization, but we do not view collective-bargaining plans as a substitute for national legislation. They can help fill in temporarily, and they can supplement a good national law. Group practice and cooperative or union medical-care plans would continue functioning under health insurance, and now are a valuable method of making good service available at low cost.

We favor the provisions of H. R. 4312, and of the even more liberal bill introduced by Senator Humphrey, S. 1805, which would assist cooperatives and nonprofit associations operating hospital and medical-care plans to get needed facilities.

The Blue Cross and Blue Shield plans, although they vary tremendously from State to State, all have limitations which are so severe that they cannot be overcome. Usually membership is only on a group basis, fees are the same for everyone, regardless of income, known ailments are excluded, persons above a certain age cannot be covered, and duration and type of service are severely limited. Why try to dress them up falsely as substitutes for an effective program for everyone? Why create a crazy quilt of 50 or more different sets of State regulations or State schemes, supplemented by hundreds or thousands of varying associations, each with its own limitations, fees, and administrative staffs? Such a crazy quilt, on a so-called voluntary basis, will leave workers bewildered and ill-protected.

The very complexities of proposed substitutes are an additional argument for a unified national program. By contrast with the maze of expensive and inadequate associations in the various States, virtually all Americans would be covered. Workers would pay up to 1½ percent of earnings on incomes up to $4,800 a year. At most this would come to $72 a year. For the family with $65 a week or $3,380 a year, the annual charge would be $51. For this amount the family would be able to choose its own doctors, as at present, go to whatever hospitals were recommended, receive necessary laboratory tests, X-rays, et cetera, remain in the hospitals for 60 days a year, and longer as funds and facilities permit, and have virtually all surgical and medical costs paid, whether in the home, office, or hospital.

American workers know this is a good buy. They do not object to the compulsion involved any more than they object to paying taxes to support schools or old age and survivors' insurance. It would be better to have taxes apportioned on a still fairer basis, holding down the amount levied on pay rolls and providing a more substantial contribution from general revenues of the Government, but the bill as it stands would be far more equitable than other proposals before you.

We hope your committee in its report will cut through the mumbo jumbo and mystery that have been created to block effective action for the Nation's health. Everyone should be covered without a means test. Everyone should have full protection, insofar as professional people and physical facilities permit. The supply of doctors, nurses, hospitals, et cetera, must be increased very rapidly, as the bill we support provides. Encourage research, increase direct Government services, aid the State and local public health services, and encourage group practice and coperative medical plans, but don't permit the program to be shattered into wasteful and miserable fragments.

Health is not a local or State problem primarily. Germs work in the same way in the South or North, and they don't pay any attention to State lines. Epidemics sweep the Nation and the world, and must be fought by the same methods in the East or West.

The great medical centers service whole regions within our country. Johns Hopkins in Baltimore draws people from the entire eastern region. The Mayo Clinic in Minnesota is turned to throughout the Middle West, and from the East as well. Hospitals in Memphis, Tenn., are relied upon by people in Mississippi, Arkansas, and other nearby States. The babies of families living in nearby Maryland and Virginia are usually born in hospitals in the District of Columbia.

Only the National Government can plan effectively for efficient development and use of medical facilities. It needs the cooperation of the States, but it must not abdicate to them.

Why should we glorify the virtues of State government as it now exists in this country? There is nothing magic that makes State government more responsive to the needs of the people than is Congress here in Washington. The United States conference of mayors have spoken forcefully of the fact that in most States city people cannot meet their problems effectively because the State governments are too much influenced by representatives of rural areas. Our own State industrial union councils are continually confronted with difficulties in securing necessary labor legislation because industrial areas are so underrepresented. I have appended to my statement part of a publication of the mayors' conference entitled "Government of the People, by the People, and for the People." To quote only a few sentences:

> But in our State legislatures today we do not have equality of representation.
>
> Fifty-nine percent of the people of this country elect only 25 percent of the State legislators.
>
> Who are the second-class citizens in this underrepresented majority? They are the 84,000,000 people who live in our towns and cities; 59 percent equals 25 percent is bad arithmetic; and bad government. It hurts not just city dwellers, but everybody.

Congress may not act as quickly on progressive legislation as we would like, but its composition is more equitable than that of many State legislatures. Small States have as many Senators as large ones, but those small States increasingly contain industry as well as agriculture and mining, so that their Senators must turn to labor as well as farmers for votes.

State lines in the East were mapped out in the day of horse and buggy. We cannot amalgamate our Eastern States, but we certainly don't speak of breaking up our far larger western ones. As history marches on, we must recognize that only the National Government can deal with basic problems that are too big for the States.

Motorcars were not made on a mass-production basis and brought within the means of most Americans through organizing corporations on a State basis. Modern giant corporations have plants throughout the country, advertise in Nation-wide magazines, and sell at virtually uniform prices everywhere. The Metropolitan Life Insurance Co. and other insurance concerns similarly have found it more efficient to develop on a country-wide scale offering the same terms to Americans no matter where they live. Their operations will be still more expensive if these concerns were broken up into 48 parts. Why should Americans pay the extra cost of 48 State systems in the field of health insurance?

Let us not forget either that a large proportion of our people move from State to State. Records of the Bureau of Old Age and Survivors Insurance show that each year about 1 American in 10 works in more than 1 State in occupations covered by social insurance. Our people are already suffering from the loss in benefit rights that result under State unemployment-compensation laws for people who move from State to State. We also know the tremendous complexities and inadequacies of that State set-up. We do not want them repeated.

The other bills before Congress would leave the American people in a medical maze, still groping blindly for good health and financial security. The Taft and Hill bills in the Senate carry the degrading means test, would not insure middle-income groups, and shatter the program among the States.

The Flanders-Javits bill, S. 1930, H. R. 4919, avoids the first two evils but would pile up a vast confusion of competing plans aided by Federal funds but dependent on changes in present State laws and on regulations drawn up by the States. Far more Government supervision would probably be required than under the bill we support, but it would be exercised by 48 States as well as Washington. The program would be costly, because of duplication. It would fail of its goal because the individual or group would be forced to choose among a bewildering array of plans, many of them inadequate and most needlessly expensive. Millions would as a result fail to make any choice, remaining unprotected.

It is not only proper, but urgent, that Congress should act to promote the people's health. While you have hesitated, the Communists have taken over most of China. Their propaganda is continuous throughout the world. American democracy must prove its merits by deeds, not words. For the welfare of Americans, for our strength as a Nation, and for our prestige abroad, Congress should, without further delay, enact this broad program to improve health and insure the costs of medical care.

Mr. Chairman, may I present for the record the excerpts from that publication of the conference of mayors?

Mr. Sadowski. Without objection, it will be accepted for the record.

(The excerpts referred to are as follows:)

Excerpts From "Government of the People, by the People, for the People," Published by the United States Conference of Mayors

Government of the people, by the people, for the people?

Why the question mark?

Certainly we believe it.

Don't we actually have it?

In our State legislatures the answer is "No."

Representation is the basis of our structure of government. Unequal representation is not democracy.

Equal representation is not a mere theory or doctrine. It is a fundamental feature of democracy; and the failure of any legislative body to enforce the principle should be met with instant and vigorous protest on the part of the people affected. The importance of this principle was well expressed by the Supreme Court of Kentucky (*Ragland* v. *Anderson*, 125 Ky. 141) some years ago when it said:

"He has studied our constitution in vain who has not discovered that the keystone of that great instrument is equality, equality of men, equality of representation, equality of burden, equality of benefits. * * *

"Equality of representation is a vital principle of democracy. Without equality republican institutions are impossible. Inequality of representation is a tyranny to which no people worthy of freedom will tamely submit. To say that a man in Spencer County shall have seven times as much influence as a man in Butler or Edmonson County is to say that six men out of every seven in those counties are not represented in the government at all. They are required to submit to taxation without representation.

"Equality is the basis of patriotism. No citizen will, or ought to, love the State which oppresses him; and that citizen is arbitrarily oppressed who is denied equality of representation with every other of the commonwealth."

But in our State legislatures today we do not have equality of representation.

Fifty-nine percent of the people of this country elect only 25 percent of the State legislators.

Who are the second-class citizens in this underrepresented majority? They are the 84,000,000 people who live in our towns and cities. Fifty-nine percent equals twenty-five percent is bad arithmetic—and bad government. It hurts not just city dwellers, but everybody.

Our urban millions are underrepresented today because:

1. Area representation (with no regard for population). Each town or county, no matter how populous, is represented sometimes equally in the upper house of most States.

2. Failure to reapportion (in accordance with population changes). Both growing and declining districts elect the same number of State representatives as they did years ago in both houses of most States.

Situations like this exist in all parts of the country.

Michigan (lower house): Wayne county (Detroit), 40 percent of population, 27 percent of representation.

Georgia (lower house): Fulton County (Atlanta), population 393,000, 3 representatives; Echols County population 3,000, 1 representative.

Delaware (both houses): New Castle County (Wilmington), 67 percent of population, 42 percent of representation.

Oklahoma (lower house): Oklahoma City, population 244,000, 7 representatives; 7 rural counties, population 57,000, 7 representatives.

California (upper house): Los Angeles County, 39 percent of population, 2½ percent of State senators.

Missouri (lower house): St. Louis, population 816,000, 18 representatives; 18 rural counties, population 158,000, 18 representatives.

Oregon (both houses): 55,406 urban people per senator, 9,072 rural people per senator, 22,202 urban people per representative, 5,272 rural people per representative.

Connecticut (lower house): Hartford, population 166,000, 2 representatives; Colebrook, population 547, 2 representatives.

Pennsylvania (lower house): Allegheny County (Pittsburgh), population 1,400,000, 27 representatives; 36 rural counties, population 1,200,000, 36 representatives.

Illinois (both houses): Cook County (Chicago), 51 percent of population, 37 percent of representation.

Colorado (lower house): Denver County, 21,500 people per representative; Baca County, 6,207 people per representative.

Ohio (lower house): Cleveland, 16 percent of population, 7 percent of representation.

Maryland (both houses): Baltimore, 47 percent of population; 29 percent of representation.

Wisconsin (lower house): 67,447 urban people per assembly district, 15,827 rural people per assembly district.

Iowa (upper house): Polk County (Des Moines), population 195,835, 1 senator; Mahaska County, population 26,485, 1 senator.

Rhode Island (lower house): Providence, 36 percent of population, 25 percent of representation.

Montana (upper house): Silver Bow County (Butte), population 53,207, 1 senator; Petroleum County, population 1,083, 1 senator.

Urban underrepresentation has its origins in our early history as a rural nation.

By 1790 constitutions for the Thirteen Original States had been adopted. In that year there were less than 4,000,000 people in the whole United States. Ninety-five percent of them lived on farms or in tiny villages, widely scattered, each small group quite isolated and having its own particular interests in its own township or county. It is not surprising that each town or county wanted to have some representation in the State legislature. Provision for this area representation was the only departure from equal representation of the electorate in early State constitutions. Some State constitutions still provide for it.

Only 5 percent of the people lived in cities and towns of over 2,500 people in 1790. This small minority was generally distrusted by the farmers who made up the bulk of the population. Rightly or wrongly, cities were regarded as "ulcers on the body politic" and their people as "immigrants and criminals and general rabble." Cities did have representatives, however, and in one house they usually had the full number to which their population entitled them. But throughout our early history, towns and cities were so few and so small that altogether their voices in the State legislatures were few.

All State constitutions provided, however, for periodic reapportionment, usually every 10 years, to take account of population changes. Equality of representation became the constitutional rule in most States and in the others only the provision that each town or county have at least one representative was a departure from this basic principle of democratic representative government. These constitutional principles, however, have not been lived up to in practice.

It continued as we became an urban Nation.

As the Nation grew, the bulk of its increase was in urban population.

But these new urban millions did not get their fair share of representation. State legislators, predominantly from rural districts, blocked the periodic reapportionment provided for in the State constitutions and so maintained their own jobs and their own control.

In most States today reapportionment is overdue. Mississippi has not reapportioned since 1892, Kentucky since 1893, Illinois since 1901, and it is, 10, 20, eevn 30 years overdue in many others.

What started as a little underrepresentation, a minor slight to a small urban minority has become today a gross injustice to 84,000,000 people.

Mr. SADOWSKI. Does that complete your statement, Mr. Carey?

Mr. CAREY. Yes, sir, it does; except to say, Mr. Chairman, that the Committee for the Nation's Health is an organization in which the CIO participates with other American organizations in this country. We have, representing the CIO, an honorary vice chairman of the Committee for the Nation's Health, Mr. Philip Murray who I promise you, without any qualification, is not a Communist.

Mr. SADOWSKI. You do not think that Congressman Dingell of Michigan is taking counsel from the Communists or subversives?

Mr. CAREY. I certainly do not. And I may say that Emil Rieve is a member of the Committee for the Nation's Health, and we have participated in that organization very actively, and we participated in the drafting of that resolution against communism in all its forms. And I do think that that organization has performed valuable service in this country in the direction of removing the causes of communism, and the conditions on which communism thrives. And when we carry out the program of that committee, through the enactment of the legislation before this committee, I am sure we will give the Communists a good set-back, because they will have less to cry about, and we will show that our country can be strong and provide for the needs of the people.

Mr. SADOWSKI. Are there any questions, gentlemen?

Mr. BIEMILLER. Just one brief point I would like to have Mr. Carey pursue further.

Mr. Carey, you referred in your statement to the fact that in various collective-bargaining procedures at the present time, the representatives of CIO unions are bargaining on health-and-welfare plans. You referred only briefly to the fact that you thought those plans could continue as in integral part under the terms either of H. R. 4312 or the Senate bill of Senator Humphrey.

Could you develop that theme just a bit further? I find there is a good deal of interest in that.

Mr. CAREY. I raised the point, Congressman, because when we deal with the employers, they tell us that this proposal that is presented in a matter that should be dealt with by the Federal Government, and the Federal Government in some cases insist that is is a matter that should be dealt with by the States, and in the States we find, despite the long opportunity they have had to provide decent health standards for the people, they have been inadequate in doing so. In fact, they have failed miserably. So there is a shuffle going on, a pushing from one to the other, and time is being wasted.

We are attempting in our collective-bargaining negotiations, to meet primarily the problem growing out of the peculiar conditions in an industry. There are certain conditions that can be corrected, but there are also certain facilities that can be provided to meet the peculiar needs of the workers in that industry, whether it be mining, or steel or any of these various industries in which there are labor organizations.

However, we do not look upon our program in the field of collective bargaining as being a substitute for action by the Federal Congress. We look upon it as being supplementary to it. And we are hoping that with the immediate enactment of legislation, H. R. 4312 or similar legislation, the collective-bargaining program can be geared in on a supplementary basis.

Mr. BIEMILLER. In a debate that I had recently on the subject of H. R. 4312, my opponent suddenly became quite concerned that if we passed national health insurance, union business agents would not have anything to bargain about with their employers. He was advocating these voluntary plans that you are after. I am sure that you have plenty of things to keep you busy, besides bargaining.

Mr. CAREY. Yes. That same argument is also used, as you well know, when you consider minimum-wage legislation. We are told that if you enact decent minimum-wage legislation, it will cover the needs of unions.

We have no concern that we will run out of work. In fact, there is an important conference going on in the city of Atlantic City at the present time dealing with the subject before this committee.

I reviewed the proposals of the American Medical Association, and I might say, Congressman, that it might be desirable to apply the same provisions of the law that are applied to labor organizations, and men like Philip Murray, Emil Rieve, Jim Carey, and the rest of us, to that labor leader Fishbein, who is the head of the union of doctors. At least, he is their spokesman. And I am quite certain that if you applied the same standards, and if we engaged in a campaign to collect $25 for each member of our union, it would give you a little bit of concern on the floor of Congress about what direction this is taking. And the policies that that organization has advocated over the years would indicate to me, certainly that when this legislation is enacted, and a time elapses, the AMA will be advocates of this compulsory national health insurance program.

Years ago, the AMA opposed the formation of community boards of public health.

The AMA, years ago, opposed the compulsory reporting by physicians to a public body of communicable diseases.

In 1921, the AMA was in violent opposition to Federal grants in aid to public health agencies.

The National Tuberculosis Association was initially opposed by the AMA when it was organized to deal with the national problem of tuberculosis.

Down through the years, the AMA has been consistently opposed to group practice of medicine brought about by voluntary organization of citizens and local physicians.

The Mayo Clinic had to fight the AMA to establish itself and to maintain its early existence.

The AMA opposed Workmen's Compensation designed for the protection of workers injured in industry.

In 1929, the AMA opposed medical care for veterans suffering from non-service-connected illness or disability.

In 1932, the AMA denounced all group practice as communism and socialism.

In 1934, the AMA opposed the institution of the Blue Cross plan, which is the hospitalization plan.

During the war, the AMA had to be indicted in the Federal courts in Washington under the antitrust laws because of the tactics it used in opposing the formation by citizens and physicians of the Group Health Association.

Subsequently, the AMA opposed the formation of the Blue Shield plan, which provides a limited medical service for organized groups, designed along the same lines as the Blue Cross hospitalization plan.

As recently as 1948, the AMA house of delegates rejected a proposal by the Blue Shield and Blue Cross to work out a combined medical and hospitalization plan for voluntary groups.

Now, when charged with the foregoing, the reply of AMA spokesmen is that AMA will not go along with any plan until it has been tested and found good by experience. And I contend that in the face of the record, when this very practical plan is put into operation we may live to see the AMA cooperating with it. In fact, I venture to say that they might even say that they helped to initiate it. Because they contend that they participated in the initiating of some of the programs that they for years have objected to.

I point this out because it has been our experience with the AMA; and I might also say that it is the experience of other groups in other countries. There was violent opposition from the professional groups to health programs, and later these same groups, these same people, vigorously supported the programs that have been enacted in response to the needs of the people.

Mr. Biemiller. I want to compliment Mr. Carey on the testimony that he has just given, and also on his general statement. I am also pleased to note for the record that the splendid work that Mr. Murray and Mr. Rieve and Mr. Carey and their associates have done in fighting communism in America is based upon two points. First, they recognize, as good intelligent Americans, the dangers of the Communist philosophy in this country, but in the second place, and even more important, they keep fighting consistently to create conditions in America that will stop the growth of communism and that will meet the legitimate grievances of the people of this country. And I hope they will continue the work that they have been carrying on.

Mr. Sadowski. Mr. O'Hara?

Mr. O'Hara. Mr. Carey, you do not advocate, do you, that we should meet every possible objection the Communists can think up by enacting legislation to cover it?

Mr. Carey. Congressman O'Hara, I am concerned about the Communists being given credit for plans such as the one contained in House Resolution 4312. I am told that this is a Socialist plan or that it is a Communist plan. That, as an American, I resent. Because we have developed some plans here in this country that grow out of the experience we have had. I do believe we have to meet the challenge of communism. I do believe we have to prove that democracy can work in the interest of all the people. And I believe that the struggle that is going on is that the Communists are trying to attract the loyalties of the working people throughout the world.

Mr. O'Hara. I do not doubt that, and I know they like to create discord. But every time they create a discordant note, I wonder whether we should legislate. You made reference to that approach that if we would pass this legislation it would shut the mouths of the Communists.

Mr. Carey. I think if we do show that our Government is responsive to the needs of the people, we will answer the Communist charge that a government of our type cannot meet the needs of the people. In that way, I say, you do answer them, yes. And we can, I believe, show the rest of the world how people with all their differences, can live together. We have the most productive Nation in the world, and

I do believe that we can provide fine health standards and a fine standard of living much better than the Communists can and certainly much better than they have been able to do in the Soviet Union.

Mr. O'HARA. The record shows that; does it not?

Mr. CAREY. Yes, sir. I have had the opportunity of being in the Soviet Union three times in the last couple of years. And I can testify to that fact.

Mr. O'HARA. And as a matter of fact, we have a far better medical service in America today than they have in Russia. Is that not true?

Mr. CAREY. We have. Yes, sir.

Mr. O'HARA. Is it also true that we have a better medical service than they have in England today?

Mr. CAREY. We have. Yes, sir.

Mr. O'HARA. And when you speak of the Mayo Clinic, of course, I have been through the Mayo Clinic and have seen people there from pretty much all over the world. So health is an international problem; is it not?

Mr. CAREY. It is.

Mr. O'HARA. Are we going to be able to legislate on the basis of international health?

Mr. CAREY. Sir, we are not legislating on the scientific aspects of the program. We are legislating on the administrative proposition.

I think that we have an excellent school system in this country, and I believe it has to be based on compulsory features. I suppose we could present a good case as to why compulsory education is not good. Some people might say it might lead to dictatorship, or might lead to something else. But the way I view it, if you don't have compulsory education, you lead to dictatorship. There is nothing Socialist about a compulsory school education, any more than there is anything Socialist or Communist about the method that you use in bringing to your people some of these tremendous benefits that have been developed in the medical field. They are not available to working people today. They have to be made available. It is an administrative problem. And I think the Government has a role to play in that field, as it does in other fields of activity.

Mr. O'HARA. Of course, the thing that troubles me about this is whether we would, in taking this step, be launching ourselves toward complete socialism, such as they have in England. I mean, we will not lose the principles of American constitutional government all at once, except by revolution, I presume, but we can lose them one at a time, Mr. Carey. That is one of the things that troubles me in this bill.

Now, as an American citizen, do you feel that there is a danger of socialism, or a greater danger from the nonpassage of this bill?

Mr. CAREY. The passage of this bill will prevent any feeling on the part of the people that they have to change their way of living. The only way you will get socialism, as they got socialism in England, is from a situation in which industries are not responsive to the needs of the community. It wasn't the Fabian Society passing out pamphlets that caused the people to vote Socialist in England. It was because these professions and these industries failed to meet the needs of the community, and steps had to be taken in order to provide those needs.

In this particular way, with the assistance of government, our people can amply meet their needs, expanding, as is necessary, with additional facilities. But we have been subsidizing the medical profession in the same way that we subsidize the railroad industry in this country. For someone to suggest to me that TVA is socialism is to me utter nonsense. It just meets the needs of the people in that valley, and it meets the needs of the community. I don't like the idea of the TVA being credited to somebody else.

No, sir; the only time I fear a change in our way of life, or dictatorship, is when we sit back and just contend that the Government does not have to enter the field of health or the field of education, or meet the needs of the people. If we meet the needs of the people, we have nothing to fear. And, quite frankly, the Communist program is to destroy the confidence of the people in their government, especially governments of our type.

I want to help build the confidence on the part of the American people, especially the American working people, in our kind of government. The way to do that would be to show that our kind of government provides the most efficient way of dealing with the problems of the people.

Mr. O'Hara. Of course, there are two concerns that I have. One is lest there be a government which is disregardful of the needs of the people, and one is lest there be a government which in its zeal to do everything destroys the government itself. We have a two-edged problem, do we not?

I say we can ruin the government in two ways, by disregarding the needs of the people, and by going too far and destroying what the government is. Is that not true, Mr. Carey?

Mr. Carey. We could do that; yes, sir. And these things have to be dealt with on their merits and not on the basis of a formula. That is why I do not like to have the word "socialism" attached to something like this in order to discredit it.

Mr. Sadowski. On the question of our interest in international health that was raised by Mr. O'Hara. I would say that as a matter of fact I believe we have shown an interest in international health in many ways, through our Red Cross, through direct aids from our Government to other countries. As a matter of fact, this afternoon we will be called upon to vote a bill for the carrying on of the children's aid program for medical aid to the children of Europe. And, of course, I am going to vote for it, because I think it should be done. I realize that in many European countries they have an incidence now of seven times as much tuberculosis among the children as they had before the war. It is a result of the war.

I think we ought to do everything we can to help those people that are so incapacitated and are suffering from that disease. And, of course, I am glad, when I read the press, that the United States has shipped several million dollars' worth of streptomycin to Europe. I believe that part of it is a noble program. I think it is all good. I think it is humane. And, to my way of thinking, it does not look like socialism at all. It looks like Christianity. I think that it is something that Americans should be proud of, and I think that it is something that the people of the world will be most grateful for.

Mr. O'Hara. I would like to ask another question or two, Mr. Chairman.

Mr. SADOWSKI. Mr. O'Hara.

Mr. O'HARA. Mr. Carey, it is true that many labor organizations and industrial organizations have provided for health programs within those phases of industry that they represent. Is that not true?

Mr. CAREY. Yes, sir. They have in some cases been able to overcome the resistance to operating their clinic arrangements. Sometimes we are unable to overcome the opposition. There is the opposition of the American Medical Association, which is so great that it tends to discourage, in communities, the cooperative effort on the part of workers to use the resources of the organization and the cooperation of the members of the medical profession in rendering the services on a group basis.

Now, some of them have been successful. Without exception, we have had to overcome some pretty serious opposition. Where we have a local union of some 8,000 people on a prepaid basis, they could get much better services than they can otherwise. But some of the doctors that join with us in some programs or in the administration of programs of this nature have been denied the right to use hospital facilities in communities. They were denied the right to walk with dignity in their profession because they were rendering service in a better-organized manner. And a great number of them had to withdraw.

Mr. O'HARA. I don't want you to think that some of those things you have just related I approve of, either, Mr. Carey.

Mr. CAREY. No; I don't.

Mr. O'HARA. I want you to know that. I want you to know this, too: That I think this health problem is a terrifically big problem. I realize that people who are wealthy can lose all their money in costs of sickness, and I realize that this legislation or any other legislation is not going to guarantee workers good health. The program, as I understand it, would also be limited largely, under section 7 of the bill, to those who were employed. I do not think it answers the problem in that regard as to those who are self-employed or to the unemployed. But it is a great problem that we have to deal with in this entire subject. I think you recognize the limitations of this bill H. R. 4312 in that regard, do you not?

Mr. CAREY. Yes, sir. But we think this is a splendid bill. We recognize the limitations in terms of finance, as well.

Mr. O'HARA. No one knows yet what it will cost, Mr. Carey. Is that not true?

Mr. CAREY. It is not only that. As I said in my statement, we would like larger funds to come from the general revenues, rather than having so much of it supported out of the pay-roll taxes. But, despite that, the bill as it stands today we heartily endorse. And we honestly believe that, with the operation of this bill as it is now written, a great deal of the opposition to a compulsory program of this nature will change almost overnight, and those who have been in opposition will be in support of it. The fears of it will be eliminated, and the doctors will be in a position, a better position, to cooperate.

We recognize the shortcomings of any kind of legislation, attempting to do it on the basis of legislation, because sometimes there are charges made that are untrue, that are made for the purpose of discrediting a program. We think through the enactment of this program all the experience gained will be all to the good, and it will assist our Government and our people in working out what difficulties may arise.

Mr. Sadowski. Mr. Wilson.

Mr. Wilson. Mr. Chairman, I think Mr. Carey ought to be commended for recognizing that there are fears of the proposed legislation that are honest and not simply based on an effort to discredit the program. Now, the morning press carried quite an article about the American Medical Association being in assembly now at Atlantic City, and, through their house of delegates, as I read, they have seen fit to not only muzzle, but verbally spank Dr. Fishbein, who has been their editor and so-called spokesman throughout the years. Possibly they, too, can recognize that there are fears on both sides of this question, honest fears.

It may be these many things that you have read into the record that they did oppose in the past and have since proved to be at least reasonably good programs for the American people were good programs in the very inception. At least, they posed problems that were worth working on.

You made the statement a while ago that in the last 2 years you have had the opportunity to be in the Soviet Union, in Russia, on three occasions.

Could you give us the benefit of your experience as to what you observed there, if you had an opportnuity to observe, as to any medical plan or program?

Mr. Carey. They have a splendid program—on paper. Seeing it in operation leads one to believe that the plans they have are not always translated into operation. I did admire the plans they had in some of the back areas of the Soviet Union for ordinary personal hygiene, where they were able to develop it on a broad mass basis. But in the Soviet Union they have not developed the kind of work habits that would permit large-scale production. They don't have enough skilled and semiskilled workers, and they don't have the industrial capacity that would support any kind of extensive social plans.

When I am asked a question, "In the Soviet Union, do they have medical facilities or services rendered to compare with the United States?" the answer is definitely "No." They can't afford to have the standard of life or the standard of medical care that we have in this country. They have a lot of show places, and they have a type of rest home, and they have, as I said, a lot of benefits that are not derived by the people. They have, or at least did have, free filling out of prescriptions. I don't know what they call it, but they have a special name for it. They changed that. We looked into it. They didn't have the chemicals. They didn't have the things that were necessary.

It is the same in production, where they have a splendid program of distribution but they have nothing to distribute. And the situation that you see in the Soviet Union is that their literature is much better than the actual practice, the performance.

I went to some of their rest homes and looked over some of their hospitals and went to some of their schools, because as an officer of the CIO I had a measure of freedom that is not usually accorded a visitor. And, as we would drive down a road, I would ask to stop and go into a school or another building. Without having a Cook's tour arranged, I thought I would see more. And I took moving pictures of these visits. I can say very definitely that the services rendered to the workers in the Soviet Union that they glorify so much are not anywhere near the standards of this country.

I would expect that the standards of the United States would be much higher than the standards of health in England, or the standard of living, because, as I see it, the industrial and agricultural production is what supports our Government, what supports all the services that are rendered. And we can afford to have higher standards in terms of health and living than any other country in the world. And. in fact, we can't afford not to have the highest standards and the most that are rendered. And we can afford to have higher standards in the interests of the whole community.

Mr. Wilson. What is their medical plan in the way of state assistance, if any?

Mr. Carey. It varies according to the community you go into. It is very definitely a state-operated system, very definitely such, as everything else happens to be, except perhaps a shoeshine person. But over there you can't hire anyone else to engage in any work. You can work on a free-enterprise basis yourself, but you can't employ anyone else to work with you. So that limits your free operations to a very few services.

Mr. Wilson. Do they designate which doctors are to treat a particular cooperative or group or community?

Mr. Carey. The plans I saw were identified with the factory or the place of employment. The hospital would be attached to the factory. The doctors would be attached to the factory. A number of people would be assigned to a particular group or area, and they would be required to live in a certain vicinity. There is no measure of freedom, and there is really no comparison between the system operating in the United States as against the Soviet Union. From what we saw of it, we don't like it. That is why for somebody to suggest that this is a Communist plan that is contained in this piece of legislation, kind of puts the back hair up on our necks, because we understand something about communism.

It is easy to be opposed to communism if you belong to the chamber of commerce or the National Association of Manufacturers, because you lose nothing by opposing communism. But when you oppose communism in a labor organization or oppose communism in the Soviet Union or in Italy or in the CIO executive board or in our local unions, you have got to know something about the subject, and it costs you something to be in opposition to communism. It is not exactly a cold war at our level. There is a little heat connected with it.

Mr. Wilson. You talked about communism creating a situation in reference to this proposed legislation, or rather that questions were asked about communism creating such a situation. Is it not a fact that communism takes hold of a situation that already exists?

Mr. Carey. The Communists, of course, design their program to take advantage of a popular cause or a condition that exists. They thrive on chaos and confusion. That is why the Communists are particularly active following a war. The resultant chaos provides the Communists with unusual opportunities. The way to deal with that would be through the proper kind of political and economic program, as we are doing in Europe. Not only are we projecting the Bill of Rights. We are also projecting some things that workers understand—tools, seed, fertilizer, things that they need in their homes and on their farms and in their factories—so that they can eliminate the chaos and confusion.

I do believe that that kind of an effective program is something more than just slogans like "free enterprise" and "democracy," because we give the people a chance to reconstruct. And, Congressman, it is not only the streptomycin we send over there, but when we send over a machine or a way of handling that machine or some fertilizer or some food, that is just as much needed in terms of the health standards of the people of Europe as anything else.

Now, if we permitted their fate to be lost in their future, the Communists would have easy going. And it is true you will find there are Communists in the ranks of the labor movement. If we have a major depression, you will find a lot of Communists in the unemployed organizations. You won't find any in the investment bankers, or very few; because, in the first place, the Communists don't try to gain control over the investment bankers association. They do the labor organizations. And, if you have sweatshop conditions, the Communists will have an opportunity to make hay there and gain advocates.

If we discriminate against people because of natural differences, they will be easy victims of the Communists.

So the effort would be, in a democracy, the kind of democracy that we have in the United States, for a fearless approach to the question, directed toward solving the problems of the people and rendering the services. When we do that, we undercut the Communists in their program. And that is what we have been doing in Europe. That is what we were doing in Italy. It is what we were doing in these other countries, as well. We are giving the Communists more than a run for their money. We are moving them back. And I have a notion that if the Communists were able to gain control over the work habits of the people of Germany there would be a great threat of a war. It is up to us to make certain that the Communists, even in the eastern zone of Germany, are not able to render services better than the democracies can render services, their own democracy particularly.

Mr. Wilson. There is one other question I would like to ask you Mr. Carey. In your statement you several times mentioned the financial barriers between the doctor and the patient.

One, the only case you cited was the Hilton case, that was referred to over on the Senate side, as they considered this proposed legislation. I notice that there were 8 months' hospitalization of Mr. Hilton, and the hospital bill alone amounted to in excess of $4.500, and the doctor bills, including the prescriptions, amounted to $770. There is a case where the hospitalization end of it was approximately 6 times that of the doctor bills.

I am still thinking that maybe there is some work to be done in promoting more hospitals, the actual construction of hospitals and the equipping of hospitals, and maybe even Government subsidy of hospitals to help solve the problem. Maybe this is not a typical case, but it is certainly a case, and it is the only one, in fact, that you presented here. But it does pose this question, in part, that the hospital bill in many instances is as much as or maybe several times more than the doctor bill.

Mr. CAREY. Mr. Hilton, of course, if he continues to be ill, as he apparently will for a while, and he is hospitalized again, can again, of course, after the period of a year, get another month's hospital bill provided by the Blue Cross plan.

Mr. WILSON. Under this existing voluntary plan?

Mr. CAREY. That is correct, sir. And this is not an unusual case in the sense that it is a low-income group. Mr. Hilton is a union member and has been for some time. He gets comparatively high income for that family. It is a family whose finances are well administered in the sense that they both had been working and providing family services; and their income was unusually large in fact for a family of that size.

But the fear is not confined to the Hiltons. It is that the workers all over have that fear of illness that can only be met by an insurance system. And I believe that that fear is as serious as the illness would be on an average basis. We should try the principle of share and share alike, because all the workers have that fear.

Mr. WILSON. Permit me to interrupt. How would you feel and what would be your comments as to solving the problem by the Government subsidizing the hospitals in a large measure?

Mr. CAREY. There is nothing particularly wrong with that. We have subsidized the automobile industry by building roads. We have subsidized the railroad industry and a great number of other industries in this country. Certainly it is to the interests of this country. We have subsidized the health standards of the people, because particularly in the event of war needs, we have been doing a great deal of that and have to do it.

Mr. SADOWSKI. The committee is highly honored by having our former chairman, the ranking member of the minority, Mr. Wolverton, here with this committee.

Would you like to ask some questions, Mr. Wolverton?

Mr. WOLVERTON. I have no question to ask, Mr. Chairman. I would appreciate the opportunity, however, of confirming what Mr. Carey has said with respect to conditions that he observed in Russia on his visits to that country.

It was my privilege as a member of the Colmer committee, immediately following the war, to visit Russia. Opportunities were given to us to observe fairly well. Our time was a bit limited, which naturally prevented us from making as wide a study as we would have liked, but certainly the time that was at our disposal and the opportunities that were afforded to us were sufficient to permit us to make certain observations.

My observations confirm everything that Mr. Carey has said with respect to the insufficiency of the actual or practical carrying out of the plans to which he has referred in that country. I came back very definitely with the impression that those who advocate communism as a cure-all should have the opportunity, and I would like for them to have the opportunity of seeing communism in action and in results. I think that would be the quickest way to cure anyone of those ideas that they express so frequently in our country.

I also feel that the statement that has been made by Mr. Carey indicates deep thought upon his part, and I think he has made a very valuable contribution to the committee in the statement that he has made here today. I feel privileged that I had the opportunity to be in here sufficiently long to have the benefit of his statement.

Mr. Carey. Thank you, sir.

Mr. Sadowski. Mr. O'Hara?

Mr. O'Hara. What is the estimate of the number of persons in this country, speaking percentagewise, who have an income of $2,000 or less?

Mr. Carey. I could secure the information, sir.

Mr. O'Hara. I have seen it reported at something like 40 percent. I think that is generally accepted. I do not know whether that is accurate. If you wish to add that, that is perfectly all right.

Mr. Carey. We could. We can have someone develop that point in later testimony.

Mr. O'Hara. All right. The reason I mention that is that an article which I read commenting upon the socialized medicine of England made the estimate, I think, that 80 percent of the people of England were persons of $2,000 income or less. It was just about double what it was in this country, as I recall it. Now, that may not be accurate. It is accurately quoted, but I mean I do not know whether the figures are accurate or not. I am only quoting what I have read. It was an article in the Saturday Evening Post several weeks ago in which I read that. I do not know whether you read the article or not, Mr. Carey.

Mr. Carey. I have the article, and have been going over it. But I pretty thoroughly enjoyed some visits I had with "Ni" Bevan. I sat in Parliament while this subject was being discussed, and had a continuing interest in it. I am frank to say that I wouldn't expect England to anywhere near approach what we can do in this country. I am not arguing the question of socialism, or anything else. I am just saying that the productivity of the American farmer and industrial worker in this country as against England can provide us with the opportunity of presenting to the people some benefits in return for their ability in terms of production; and that we can gain a great deal from the experiences they have had in other countries.

For us to gear our benefits to other countries would not be the way of doing it. I am talking now in terms of translating the progress of this important profession to more people. We have made greater advances, I am sure, than they have.

I talked with "Ni" Bevan about some of their shortcomings. They don't have a developed industry to provide the chemicals and things necessary to make available the medicines and other things. They are going to do it; that is true. But as to the wage and income levels, there, you can't buy for an hour's employment what you can get in this country.

The British worker is extremely—well, underpaid, compared with an American worker. They work harder and produce less.

Mr. O'Hara. They are underfed, too.

Mr. Carey. Yes. But they are better fed today than they were a few years back. And I am talking today somewhat in defense of the British Labor government as against the Conservative government. They are much better fed than they have been. And a large part of it is due to the fact that the United States has been so generous in helping to rebuild Europe; not just England, but Europe.

When you see the diet of the working family today and compare it with the diet of the working family sometime back you can see the improvements that they have made there.

And I might say that the health program requires, as well, other things, such as opportunity for proper food and proper housing and things like sanitation. All of those things that we have here superior to any other place in the world would give us a real opportunity in this field. I think it helps to show that we have the right way of doing things.

Mr. O'Hara. I think it illustrates, Mr. Carey, that we might profit from some of the mistakes that have been made in the field of legislation on programs like this. I mean, I think we certainly ought to be able to improve on most of the things that have been done abroad in this field, from the standpoint of industry, at least. At least our industry production is geared much higher than that of Britain. Is that not true?

Mr. Carey. That is true.

Mr. Sadowski. If there are no further questions, the committee will stand adjourned until 10 o'clock in the morning.

(Whereupon, at 1:40 p. m., the committee recessed, to reconvene at 10 a. m., Wednesday, June 8, 1949.)

NATIONAL HEALTH PLAN

WEDNESDAY, JUNE 8, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. **Priest.** The committee will come to order.

The committee is in session this morning for a continuation of public hearings on H. R. 4312 and H. R. 4313.

Our first witness will be Mr. Kenneth L. Kramer, director, insurance and health department, Textile Workers Union of America.

STATEMENT OF KENNETH L. KRAMER, DIRECTOR, INSURANCE AND HEALTH DEPARTMENT, TEXTILE WORKERS UNION OF AMERICA, CIO, NEW YORK, N. Y.

Mr. **Kramer.** Mr. Chairman and gentlemen of the committee, my name is Kenneth L. Kramer. I am director of the insurance and health department, Textile Works Union of America, CIO. Our officers are at 99 University Place, New York City.

Prior to this position, I have been in the National CIO in its general community relations program, and was also the administrator and director of the Labor Health Institute of St. Louis for some time, a prepaid medical-care plan.

The question of health insurance is not an academic matter to the Textile Workers Union of America—390,000 of its 450,000 members are covered by some form of voluntary health insurance. This percentage of coverage is far higher than is to be found in the public at large and compares favorably with the higher proportions of American industrial workers so covered.

Our experience over the past 7 years with this degree of advanced coverage has provided us with what we believe to be ample and practical experience showing beyond question that compulsory health legislation along the lines of the administration bill is what our workers need and must have.

These 390,000 workers covered by health-insurance programs in our collective-bargaining contracts represent an excellent cross section of the medical-care needs of the American people. These workers live in 36 States, scattered in all parts of this country; their income level is average. Their type of work mainly the spinning, weaving, knitting, and dyeing of textiles, is not particularly hazardous.

Two areas of medical costs are best covered by our union contracts. These are costs of surgery in the hospital and the cost of hospital room, board, and extras when surgery is required. The carriers of these programs are the commercial insurance companies and the Blue Cross and Blue Shield. Most of the insurance is with the various larger commercial insurance companies, operating on an indemnity basis. Not many of our agreements provide for doctors' bills outside of the hospital; those that do are generally both unsatisfactory and expensive.

Our experience with these programs has been most disillusioning. When we started negotiations for the insurance benefits in union contracts we were well aware that our members and their families could not afford the cost of adequate medical care. We felt that an honest effort on the part of both management and labor would result in alleviation of this financial burden. Management agreed to our proposals. In all but 5 percent of our agreements the cost of group insurance for the workers is borne fully by management.

We want to stress the fact that we have no quarrel with our employers on this score. The "voluntary" partial coverage system is at fault; not the textile manufacturers. Also we wish to make it clear that although our present coverage is far from adequate it is still far better than none at all.

The cost of the partial coverage in our branch of industry alone is $20,000,000 a year. This means simply that the present admittedly inadequate programs cost $50 per employed person. The employed member of the family gets the lion's share of coverage. But in no instance is any individual worker covered for even half of his or her normal medical care expenses.

All too often we find when we secure a contract which puts an insurance program into effect in a given community or area, that this is the signal for an increase in doctor's fees. Our members complain that a surgical operation, once costing, let us say, $100, now costs the old amount plus the amount of the indemnity paid by the insurance company. The only two parties gaining in the matter are the doctor and the insurance company. The worker still has to pay out of his own pocket usually just about what he paid before. The high cost barrier that kept him from getting medical care has not been overcome and in these cases the worker's condition is no better than it was before he was covered by the group policy.

We have not had sufficient leverage in our bargaining position to keep up to the increase in hospital costs. When we are able to obtain $6 a day indemnity from an employer instead of a $4 a day, we find that the hospital rates have risen to $8 and $10 a day during the period of negotiations. In most of our contracts we have allowances of up to 5 or 10 times the daily rate for hospital extras. These items have risen even more steeply than the rise in hospital day rates. The net result is that the worker and his family are still finding it necessary to dig into their savings, or borrow money, to pay their medical care bills.

Medical expense insurance from commercial indemnity insurance companies is supposed to cover the normal out of hospital doctors' bills. It does not. First, the individual covered must be totally disabled. Then, the payment usually does not start until the third or fourth day of illness. We find that not more than 50 percent of the premiums collected are returned to our members as payment toward their out of hospital doctor bills because of these limitations. This is a poor bargain for every one but the insurance companies.

Our studies show us that at best 80 percent of the amount of the premiums paid in are returned to workers in the form of benefits Twenty percent goes to administration and profit cost. This is an excessive percentage. Premium rates are conservatively figured on the basis of experience; the rules on claims are so well prepared that the risk assumption by the insurance company is negligible. In effect, we are supporting a small army of salesmen, brokers and other insurance company functionaries who contribute little or nothing to the securing or maintenance of these policies.

Blue Cross has the same kind of shortcomings, even though the disadvantages are less severe. The recent increases in Blue Cross rates, a 32 percent increase in New York City, as an example, have made even this limited approach to full coverage so expensive as to be out of the question. The administrative costs of Blue Cross are higher than comparable governmental and private agency costs. Rhode Island's sickness compensation law for example, operates on 5 percent of income for administration. This system works well. Blue Cross administrative costs run close to 10 percent. Much of this 10 percent is necessary because of limited area coverage and their sales and promotion costs.

Two Blue Cross plans have shifted to indemnity plans, rather than service plans, and these two—Massachusetts and Connecticut have been dropped by our members in favor of commercial insurance.

Blue Shield plans have been advanced as an answer to the cost of medical care. Our examinations convince us that only in a most limited way can they be considered as a valid approach to the problem They benefit the doctors, by insuring their bills, but do not benefit the patient by giving him security. They uniformly contain income limitations, fine print limitations, and the administraton of these plans has been dominated by the conservative forces in the medical societies.

Outside of New York City we know of no community where we can obtain at any cost, comprehensive medical care insurance for our members and their families. The New York plans we have studied are costly, but even at that are definitely preferable to the arrangements we have now. These conclusions have been reached after 7 years' daily experience with the so-called voluntary approach.

Much of the time of the Members of Congress will be taken listening to statements urging this or that nongovernmental approach as being in the right direction. You will constantly be told about the 52,000,000 covered by one form of insurance or another. The implication will be drawn that this sizeable body of the population actually has medical care insurance. We insist that this is not the case and our experience irrefutably proves our contention.

We hazard the opinion that, from now on out, the voluntary plans will decline in both coverage and services because of conditions in our economy which cannot be changed.

Unless the Government bails out Blue Cross its rate of growth will be slowed down to nearly zero. Blue Cross with its variety of autonomous plans, its patchwork, piecemeal approach, just don't do the real job. Blue Cross just cannot continue to sell insurance for hospital beds that don't exist.

Blue Shield primarily and essentially is insurance for the doctors; it is only incidentally insurance for the patient. Commercial insurance will not reduce its high administrative costs and will continue to extract more rather than less of the 20 percent toll now taken from the medical dollar. In the meantime all sorts of patchwork remedies will be suggested in a rash of new bills, compromises and partial solutions. The major problem—how can the American people get the medical care they need when and where they need it at a cost they can afford—will not be solved without enactment of compulsory health insurance legislation.

H. R. 4312 has our active, vigorous support because it goes clearly and thoroughly to the very heart of the medical care problem. Comprehensive medical care cannot and will not be achieved until all those citizens who can under our form of government be fully insured, are covered compulsorily. It will then, and only then, be possible to provide full medical care of high quality for the great majority of our people.

Mr. Priest. Thank you, Mr. Kramer.

I wish you would explain for the record just very briefly the difference in the indemnity plan and the service plan. You mentioned, I believe, that the Blue Cross in two States at least, recently had changed from the service plan to an indemnity plan.

Mr. Kramer. That is right.

Mr. Priest. Will you explain that just briefly for the record.

Mr. Kramer. The indemnity plan gives you a flat amount allowance toward the hospital day rate. In the Blue Cross plan, maybe they allow you $6 a day for the hospital costs. If it is $10 a day, you have to pay $4 out of your own pocket, and if it is $5 a day, you collect the $5 that is there.

The service plans give you a semiprivate room regardless of the individual rate of the hospital. You may get in one hospital with a semiprivate room rate of $7 and you may get into another hospital where the semiprivate room rate is $11, but the service plan of the Blue Cross does provide the full cost of that room and board in the hospital, and on a service base for, of course, the limited amount of days they may provide for. It may be 31 days, or 60 days, depending upon the individual Blue Cross plan.

Mr. Priest. Thank you, Mr. Kramer.

Mr. Biemiller. Mr. Chairman.

Mr. Priest. Mr. Biemiller.

Mr. Biemiller. I note, Mr. Kramer, that you have devoted practically all of your testimony to title VII of the compulsory health insurance features of the bill.

Do you have any comments to make on the other six titles of the bill?

Mr. Kramer. Well, we consider them essential also to national health and that they go a great way toward solving the current inadequacies that are there in services available.

Mr. Biemiller. I further note that in one place, you refer, at least inferentially, to the fact that we have a shortage of hospitals, and a shortage of services in hospitals and medical centers, and so on, as well as other facilities.

Mr. KRAMER. My testimony is more or less a postscript of Mr. Carey's of yesterday and if I had followed logically it would have tied in a little closer.

Mr. O'HARA. Mr. Chairman.

Mr. PRIEST. Mr. O'Hara.

Mr. O'HARA. Mr. Kramer, when Mr. Carey was before us yesterday, he indicated that possibly you might be able to furnish, when you testified today, the information which I requested as to the family incomes below $2,000, percentagewise, as compared to the United States and Great Britain, for example.

Mr. KRAMER. I have not been able to obtain that information, as contrasted with Great Britain. I do know in our own industry where the pay is slightly below the industrial average, most of our people are not able to qualify under the income limitations set by the Blue Shield plans.

Mr. O'HARA. What is that limitation?

Mr. KRAMER. That is $2,000 for a single person and $3,000 for a family in most cases, and if you are under the income limitation, the doctor guarantees you the fee schedule that is set. If you are over the income fixed, he can charge what he will.

Mr. O'HARA. In connection with one of the complaints which you called attention to—I think it was in the Blue Cross. Is that surgical or hospital; the Blue Cross?

Mr. KRAMER. The Blue Cross is what the hospital itself charges for room and board and extras and the Blue Shield is what the doctor charges for an operation.

Mr. O'HARA. With reference to the Blue Shield, then, you indicated that one of the weaknesses there was that the main coverage was for the worker himself, in connection, I assume, with the Blue Shield plans. Is that correct, Mr. Kramer?

Mr. KRAMER. Yes; the worker being covered is the first step we took.

Mr. O'HARA. Do you understand that this bill would protect the workers' families?

Mr. KRAMER. Definitely; very definitely. We have found it highly expensive to protect the workers' families completely through collective bargaining.

Mr. O'HARA. I mean, as you interpret this bill, the workers' families would also get free medical and surgical attention?

Mr. KRAMER. We definitely do.

Mr. BIEMILLER. Will the gentleman yield for just a moment to clear up one point?

Mr. O'HARA. Yes.

Mr. BIEMILLER. I am not sure that the record is now clear, in answer to your question, Mr. O'Hara, about those income limitations under the Blue Shield.

As I understand it, if you are a single person and your income is below $2,000, then you are guaranteed that an operation for appendicities will be performed at a fee or schedule agreed upon with the Blue Shield, and the doctor will be paid accordingly, but if you are a single person and your income is over $2,000, then the doctor can charge what he will and the Blue Shield will only pay that part of the fee that is guaranteed.

Mr. O'HARA. I so understood that.

Mr. BIEMILLER. I wanted to make sure that the record had that clear in there so that there would be no misunderstanding of it.

Mr. KRAMER. Usually, it is $3,000 for a family, and with two or three people working in the family, that is where the plan automatically breaks down and becomes unrealistic in the Blue Shield.

Mr. O'HARA. Mr. Kramer, do you feel that this legislation is discriminatory in that it only takes care of the worker and not the self-employed and the unemployed?

Mr. KRAMER. We are for a coverage as broad as it possibly can be. We do recognize that this is starting on the basis that is set up now and is a good start, just as with social security, the original social security was a good start, and we have to start somewhere, we feel, the sooner the better.

Mr. O'HARA. Now, you feel definitely that there is a shortage of hospitals in the country.

Mr. KRAMER. That is correct.

Mr. O'HARA. What do you think that the cost would be to the Government program for providing the necessary hospital facilities in the country?

Mr. KRAMER. I actually do not know.

Mr. O'HARA. It would be astronomical, would it not?

Mr. KRAMER. Well, it would be of some size. At one point, I had the mission of attempting to buy a hospital and it was a very interesting experience.

Mr. O'HARA. In that connection—this is more or less probably an observation—this committee reported out, several years ago—I think the entire committee supported it enthusiastically—what was known as a hospital aid program to the States. Incidentally, in my own district, in small towns, three hospitals have been built or are being built under that program. Each of them were badly in need of hospital facilities. Amazingly, in connection with the cost of those hospitals—most of them are being built by municipalities,—the cost of the hospitals is very great. The cities bonded themselves, in at least two instances to their limit, and considerable money was contributed by voluntary subscriptions, and even then the bids for the construction of those hospitals ran above estimates. They just went out and raised some more money by voluntary subscription and built those hospitals.

Now, of course, Mr. Kramer, I think we all, as practical individuals, and you as a practical person, recognize that is the same problem we have in building our hospitals throughout the country. Is that not true?

Mr. KRAMER. I think the Hospital Construction Act of a few years back has been beneficial.

Last week I was in Danville, Va., where a community subscription of a sizable amount plus the State and Federal grants enabled those people to provide 100 extra beds in a community where they were sadly needed. People were going as far as 80 to 100 miles from that community to get hospitalized. And down in a little town in North Carolina last Saturday a week ago, they passed a county-wide bond issue for a hospital. That will solve some of our problems down there.

I do think one thing has happened in medical care and that is there has been an undue proportion of attention paid to hospitals and not to the problem as a whole. People have assumed that if you build enough hospitals you have more or less solved your medical care problems.

While, actually, about 25 percent of the medical care problem is a hospital, you need all sorts of facilities out of the hospital, and I note with a certain amount of alarm that several of these hospitals that I have been in touch with that are now in building, do not provide outpatient facilities. There are inadequacies such as diagnostic facilities for the person who is not in the hospital and unless he is admitted he oftentimes cannot find out just what is wrong with him without going to a teaching center in the State capital, or something like that, to find out what his ailment is. Actually, the local community doctors are doing the best they can with inadequate equipment in their own offices, and I know of individual cases where people have had prolonged illnesses mainly because they did not get adequate diagnostic care and service soon enough and when they are in a hospital, of course, they are sick. Our emphasis has been in all our discussions and thinking about this on preventive medicine and that requires thinking beyond the hospital situation itself, as serious as that is.

Mr. O'Hara. Also it is quite important, Mr. Kramer, that a hospital be operated on a business basis, or they would run into financial difficulties, is that not true?

Mr. Kramer. That is very definitely true. I had individual dealings with a number of excellent hospitals on patients whose bills I had to pay, in my St. Louis experience, and I found a wide variation of business responsibility in the hospitals and great difficulty oftentimes in finding out the true costs.

Another thing I might just add here on the whole subject of hospitalization costs, and that is the Blue Cross has shoved the major responsibility for hospital maintenance from one group of the population to another group through its program of insurance. Previously, hospitals ran on contributions from the well to do; contributions from community chests, and some tax funds that were supporting the indigent who used the free beds. Since the inception of the Blue Crosses, the hospitals have regarded the industrial worker and the middle-income group covered by Blue Cross as their major source, and I would like to see what has happened to private giving to hospitals in the past several years. Friends of mine in the fund-raising business say that it is pretty tough to get big gifts for hospital endowments and new buildings and things like that, and hospital campaigns generally have had a tough time in raising money, because there has been this shift in emphasis on who provides the real financial basis, and right now it is the Blue Cross subscriber, and I know places where counties and municipalities are still paying $2 and $3 a day for the indigent, and the well-to-do have pretty well stopped their contributions, except under extreme pressure, and as a result the hospital's rate for the Blue Cross subscriber goes higher and higher, to the point where they are pricing themselves out of a market.

Mr. O'Hara. Well, of course, as you know—at least, I think we all know—most of these hospital costs of operation have gone up tremendously. Is not that true?

Mr. Kramer. They have increased.

Mr. O'Hara. Yes. Even in the little hospitals out home, the nurses are organizing unions now. Is not that true?

Mr. Kramer. True, and good.

Mr. O'Hara. The workers are also all organizing unions now, and they are all getting bigger salaries and getting higher wages. Is not that true?

Mr. Kramer. Another thing that has been happening in the hospitals is that the hospitals are doing more and more of the services that doctors formerly did, by their staff people. In some cases, the medical societies are a little unhappy about the paid staff in the hospital doing services a doctor formerly did on a fee basis. What it does add up to is more costs for the patient. This business of hospital extras, the X-ray, laboratory, and other services in the hospital have risen actually more percentagewise than the increase in the room and board and nursing services, and many hospitals have tried to solve their budget problems by doing that job in the hospital.

Mr. O'Hara. Of course, Mr. Kramer, my limited observation of hospitals leads me to observe that sometimes the laboratory is one of the most important pieces of treatment that the patient gets, to find out what is wrong.

Mr. Kramer. It is extremely essential. There is no question about it. And, my only complaint is that they cost a great deal more than their actual cost figures would demonstrate.

Mr. O'Hara. I think there is some justification for that statement.

Mr. Kramer. Anyone who has been there knows that.

Mr. Priest. I have been doing just a little mental calculating here, after Mr. O'Hara raised the question he did, as to what the cost would be to furnish adequate hospital facilities for the country. This would be more or less an estimate; but, based upon testimony before the committee at the time we passed the Hospital Construction Act, I think the figures would run something like $1,125,000,000.

At that time we authorized $75,000,000 as the Federal part over a period of 5 years. That was only one-third of the anticipated expenditure, which would make it $225,000,000; and at that time it was testified by some authorities that this bill, when the funds were completely utilized—Federal, local, and State—would meet only 20 percent of the Nation's needs.

On that basis, if that is a good estimate, then the answer to that question would be about $1,125,000,000, to furnish the adequate hospital facilities.

Mr. O'Hara. Mr. Chairman, I would like to add this comment: that that would only be a drop in the bucket.

Mr. Priest. I am inclined to think that it is not too many drops, but it is the best estimate I have available at the time.

Mr. Wilson, do you have any questions?

Mr. Wilson. Yes, Mr. Chairman.

I want to make an observation along that same line that the Hospital Construction Act is worthy and laudable in its aims and objectives and purposes; but, when we get down to the grass roots such as in my State, they have hardly seen the corner of the bucket, and the bucket is round. Hospital beds are not there, and I think your observation and your testimony—that people are buying, by voluntary plans, hospital beds that are not there—is correct. In my own town, nearly 99 percent of the capacity is full all of the time, and the national average should not be over 80 percent, to provide for emergencies.

You speak of people who might go 60 to 80 miles to a hospital. In my district they are going 200 and 300 miles, and they do not have access to the hospitals or specialized facilities then.

Now, you speak in your testimony, Mr. Kramer, of your own textile organization, and you say that you have about 450,000 members, or a little less than half a million, and you say that is a pretty good cross section of the worker group of America.

I see here that you say that 390,000 of those people are covered by some form of voluntary health insurance. That would be a little bit more than 86 percent of all of your people have some sort of voluntary coverage.

Why is it that the other 13⅓ percent of your people cannot have some coverage?

Mr. KRAMER. We have not been able to get it in the collective-bargaining agreements.

The places that do not have it are the newly organized plants in the South where we are in our first or second year of contractual relations. First, we got the wages up to standard, and the grievance procedures worked out, and the seniority clauses, and we have not been able to obtain the insurance provisions as yet.

Some of the cases where we did organize the plant, the wages were substandard, and our first job was to get them up to industry standards, and eventually we will get some form of coverage for those 13⅓ percent not covered.

Mr. WILSON. You say "eventually." That is, the objective is to get coverage for even that other 13⅓ percent?

Mr. KRAMER. Definitely.

Mr. WILSON. The coverage that they do have now and the one you are striving for is only a partial coverage; is that correct?

Mr. KRAMER. We are striving for the maximum. We can only buy a partial coverage on the voluntary plans, at best.

Mr. WILSON. At the present time, the only thing you can buy is partial?

Mr. KRAMER. There is no way we can obtain comprehensive medical care.

Mr. WILSON. Now, I notice here further down in your statement you speak of that and use the words "comprehensive coverage."

Will you, for the record, explain what you mean by comprehensive coverage of medical care?

Mr. KRAMER. By "comprehensive coverage," we mean fully available physicians, dentists, hospitals, diagnostic centers, drugs, surgical appliances, and so forth, for the worker and his family.

Mr. WILSON. That term "comprehensive" is a much-used and recognized term in any insurance; is it not?

Mr. KRAMER. That is right.

Mr. WILSON. It means coverage of all expenses?

Mr. KRAMER. Yes.

Mr. WILSON. We have comprehensive insurance in speaking of car insurance, automobile insurance.

Mr. KRAMER. That is correct.

Mr. WILSON. I see you speak of the kind of bargaining agreements you have for your workers, and you say that the employer carries all of the expense of this coverage except in 5 percent of your agreements.

Mr. KRAMER. That is correct, and in the other 5 percent they are on a partly paid basis, what we call contributory insurance. The worker contributes a certain amount.

Mr. WILSON. What is that percentage that the workers contribute in that 5 percent?

Mr. KRAMER. About half of the cost; 50 percent of the total insurance cost. We are eliminating those gradually also.

Mr. WILSON. Where the employer is carrying all of the cost?

Mr. KRAMER. Yes.

Mr. WILSON. But you say and your complaint is that the worker has to pay what he normally paid before that coverage; over and above that amount?

Mr. KRAMER. In many instances, that is correct.

Mr. WILSON. You speak here of—and I want to quote it, because I would like to have your reasons why:

> We hazard the opinion, that from now on out the voluntary plans will decline in both coverage and services because of conditions in our economy which cannot be changed.

Now, what conditions do you mean, and why cannot they be changed?

Mr. KRAMER. We feel, in this instance, the voluntary plans have reached their acme; that, from now on in, we have found that it is more and more difficult to keep up with the increase in cost of Blue Cross first and to sell our people on the idea that the indemnity program, through commercial insurance, is a good buy. If we can bargain for a $6-a-day allowance for hospital beds and the community rate is $11 and $12, our people are more apt to think perhaps that is not a good bet for them to have that kind of insurance. They would rather have the wages. Also, a shrinkage of employment in our industry brings up a real problem on lay-offs; coverage during lay-offs.

We also in some cases have a fixed amount for insurance per worker. The insurance rate is figured on the normal number employed. When that drops down, the insurance company starts thinking about cutting the benefits.

All of those things add up to an increasing skepticism and unwillingness of our people to trade off an insurance benefit for an increase in wages, which it actually amounts to in the long run. There is just so much money in the cost pattern for the industry. We can either get it in wages or we can get it in insurance benefits, and our experience has been that we are having a harder and harder time maintaining Blue Cross because of this increase in cost; because, Blue Cross being on a service basis, the cost goes up with the hospital cost. The commercial insurance companies can keep a uniform rate because they are on an indemnity basis regardless of the cost of the hospital beds.

Mr. WILSON. Yesterday, Mr. Carey spoke on something about the opposition of the medical fraternity itself, maybe as individuals or so-called spokesmen, in the AMA standing in the way or opposing increases in benefits of various steps that have been taken in social reforms relating to medical care.

Are they continuing to stand in the way in the bargaining of employees to get more benefits from the voluntary plans?

Mr. KRAMER. We have found it extremely difficult to find a comprehension on the part of organized medicine of what we are talking about when we talk about comprehensive medical care. We have found them unapproachable in many instances. We have found them toplofty in that when a layman comes in to discuss medical-care problems; we have had our ideas rejected on the basis that they have been practicing medicine in that town for so many years and it frankly is not any of our business to come in with any suggestions on how we might work together for comprehensive medical care, and a great many other experiences such as that.

It is not an easy matter to try to work with doctors, cooperatively, on an organizational basis.

I might say they will tell us what they have worked out in the Blue Shield and on a take-it-or-leave-it basis.

As an example, we have practically no labor people on Blue Shield boards anywhere in the country. I know of two or three. Most of them are doctors, and they draw in a few prominent businessmen who serve as the respectable window dressing for the whole program.

We have had a variety of individual experiences where we have attempted to cooperate on voluntary plans with medical societies, with some of our own ideas being expressed getting nowhere, and it has been quite discouraging. They are not on medical ideas, I might add. They are ideas on the economic side of medicine.

We have no complaint about the way they practice, or anything like that.

Mr. PRIEST. If there are no further questions, we certainly thank you, Mr. Kramer.

Mr. KRAMER. Thank you.

Mr. PRIEST. Our next witness will be Mr. Nelson H. Cruikshank, director of social-insurance activities of the American Federation of Labor.

Mr. Cruikshank?

STATEMENT OF NELSON H. CRUIKSHANK, DIRECTOR OF SOCIAL-INSURANCE ACTIVITIES, AMERICAN FEDERATION OF LABOR, WASHINGTON, D. C.

Mr. CRUIKSHANK. Mr. Chairman and members of the committee, my name is Nelson H. Cruikshank, and I am director of social-insurance activities for the American Federation of Labor. My office is in the American Federation of Labor Building, 901 Massachusetts Avenue NW., Washington, D. C.

I wish to express to this committee my appreciation for the opportunity to appear as a representative of the American Federation of Labor. My purpose in appearing here today is to present on behalf of the nearly 8,000,000 members of the unions affiliated with the American Federation of Labor our support for House bills 4312 and 4313, together with some of the supporting reasons for this position.

The views that I present are not just my own. They represent the views of the American Federation of Labor as they have developed in conventions of our organization and by the social-security committee in the discharge of obligations placed upon it by convention action.

It was more than 10 years ago that the American Federation of Labor first adopted a resolution supporting national compulsory health insurance. This was in 1938. Similar actions were taken by the conventions of 1939, 1941, 1942, 1943, 1944, 1946, and 1947.

The executive council of the American Federation of Labor, meeting in August 1948, reported to our sixty-seventh convention in part as follows:

> One of the major gaps remaining in our social-insurance program is its failure to provide for the costs of medical care. We know that about a third of the cases of public dependency arise through instances where, through no fault of their own, workers have had to meet serious medical costs for themselves or members of their families that they were unable to pay. We have no desire to "socialize" the practice of medicine, but we agree that it is entirely feasible to spread the risk of the cost of illness by application of the compulsory-insurance principle so that no worker need to labor under the constant fear of disastrously high doctors' and hospital bills.
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> Meantime, the interest and demands of our membership and of people generally for providing for the costs of medical care through insurance continue to grow. The failure of Congress to act has not prevented many of our unions from providing some protection through collective bargaining. While this method is the best available at this time, we recognize that it is not as sound nor as practical as the comprehensive program envisaged in the Wagner-Murray-Dingell bill (S. 1606).

This is, of course, as of last August.

The sixty-seventh convention met in Cincinnati in November and, in addition to adopting this report of the executive council, unanimously adopted the following declaration on health insurance:

> A comprehensive program to provide and meet the costs of medical care and service by the extension of social insurance should be established. Such program must preserve the individual rights of both patients and physicians. The program should include provision for an extensive program for the construction of hospitals and health centers, the training of medical personnel, and development of research.

This declaration has a somewhat different emphasis than earlier convention actions. It does not represent a retreat from earlier stands on the subject of health insurance but a step forward. The new emphasis is on recognition of the necessity for a comprehensive program which includes the training of medical personnel and development of research and in which health insurance is the keystone of the arch.

The Cincinnati convention also directed the social-security committee to work out in more detail the standards applicable to such a comprehensive health program. This was done in January of this year. The committee reported the detailed specifications of this program to the executive council which met in February. The executive council adopted this program in full.

Last month the executive council which has the authority of the convention between convention sessions held its second quarterly meeting of this year in Cleveland, Ohio, and it voiced its specific approval of H. R. 4312 and H. R. 4313.

We note that there no longer seems to be a question as to the need far a different method available to the great mass of our population for meeting the costs of medical care and services. Ten years ago when our organization first espoused the cause of compulsory health insurance, the opposition forces claimed that there was no need for any change in the method of payment. They have since shifted ground. The high and unpredictable cost of medical care is recognized. Even the most outspoken opponents of national health insurance now admit that there is a need for a new method for meeting the costs of medical care and we find them warmly espousing the programs which only a few years ago they labeled as "socialism and communism—inciting to revolution."

The hearings of the Senate Subcommittee on Wartime Health and Education and on the various proposals that have been before the Congress in the last several years have served to establish the existence of this need beyond any doubt. The problem which confronts your committee now is that of determining the method by which this need can be met.

There are some who claim that the rapid increase in membership in so-called voluntary health insurance plans guarantees that if nothing is done by the Federal Government universal coverage will be achieved within a short time. They claim up to fifty-odd million persons now afforded protection against the costs of medical care through voluntary agencies.

While many who hold this view undoubtedly make their claims sincerely, it must also be pointed out that the chief spokesmen for this approach to the problem are those who hold official positions in these organizations. We have not observed mass support from the membership of the voluntary insurance organizations, such as Blue Cross or Blue Shield, for the proposition that these organizations offer adequate protection.

Moreover, when the claims of membership are analyzed, it is found that they frequently include duplications. The present Blue Cross membership, for example, is about 33,000,000. There are about 10,000,000 in Blue Shield. But practically all the Blue Shield members are also members of some Blue Cross plan. There is similar overlapping in the numbers of persons who carry commercial insurance protection. The insurance companies estimate that about 21,000,000 individuals have hospitalization policies; about 15,000,000 have policies for surgery and obstetrics and about 2,000,000 are entitled to certain additional services.

This total coverage breaks down into three groups: (1) Those who have hospitalization insurance combined with limited physician's services in hospitals, about 27,000,000. (2) Those who have hospitalization insurance alone, also about 27,000,000. (3) Those with comprehensive medical care insurance, about 3½ million persons or less than 2½ percent of the population.

Only those in group 3 have full protection against the cost of medical care, including physicians' services for preventive procedures as well as for care in both ordinary and catastrophic illnesses, hospitalization and other medical services. These persons have nearly 100 percent protection. Those who have hospitalization insurance combined with some physicians' services in hospitals, group 1, would have protection again about 35 percent of the average family's total medical expense, if the insurance represented full protection for the services, which it rarely does. Those with hospitalization insurance alone, group 2, would have about 21 percent protection if the full hospital bill were assured. However, exclusions in most plans prevent full coverage of even this limited item.

And if the committee so desires, I can illustrate from some specific plans on the exclusion of coverage and costs.

While the growth in membership in these so-called voluntary plans has been impressive during recent years, an analysis of the geographic distribution of membership gives cause to doubt their ability ever to provide protection for all the people. Sixty percent of the Blue Cross membership is concentrated in six industrial States. Less than 3 percent of the rural population are subscribers. Sixty-five percent of the Blue Shield membership is in seven high income States. Moreover, there are six States that provide no medical service plans—only a list of approved insurance carriers providing cash indemnity. The comprehensive service plans are usually provided through consumer organizations, labor unions or cooperatives, and 22 States have legal restrictions against such consumer controlled plans.

The contribution rates of many of these plans are comparatively low. But the rates are low because the protection is so limited. In the plans affording full protection the flat rates that have to be charged the rich and poor alike as required by the insurance laws of most States put them beyond the reach of working people who have families.

We submit that these facts seriously challenge the glib claims that if left alone the voluntary health insurance groups will meet the problem of the cost of medical care.

In recognition of these realities some are proposing that the Federal Government, through an elaborate system of subsidies to be made available through the States, make it possible for the great masses of people who are now without protection to obtain it through the existing agencies, providing they meet certain standards of service and administration. In essence such a proposal represents a transfer of a recognized governmental responsibility to private organizations. While the proposal represents very desirable objectives, the degree of policing required on the part of the Government raises the question as to why the Government should not logically operate the plan which it is called on to finance and control.

Then there are those who propose to meet the problem by providing aid to those whom they term "medically indigent" or who are unable to meet all or part of the subscription costs in existing plans. The difficulty with this approach is that it fails completely to meet the health needs of working people. The people whom I represent and who have consistently asked for health insurance are the self-supporting, employed working people of the middle-income group. They are constantly confronted with the problem of how to meet the high costs of medical care. Such a plan does nothing for them. In order to be eligible for benefits a person would first have to be certified as needy after investigation of his finances. This is repugnant to the American working people and will never be accepted by them as a substitute for health insurance.

Moreover, who is to determine and how is he to determine whether the head of a family is able to pay a part of the subscription charges? How is he to determine what part the individual is able to pay? How is he to determine at precisely what point a hitherto self-supporting family, whose breadwinner is deprived by illness of the opportunity to earn his own support, becomes unable to pay all or a part of the charges? How, indeed, except by prying into the personal affairs of this family?

In contrast to the timorous, half-hearted, and, in many respects, ill-advised approaches to the problem set forth in the many proposed substitutes for health insurance, H. R. 4312 and 4313 present a complete and comprehensive program to meet the health needs of the Nation, resting on the firm foundation of the proven principle of contributory social insurance. The health insurance program established in title VII of this bill is based on the principle that people should pay their way in proportion to their means, in this case by small regular payments into the insurance fund, and should therefore have needed medical services as a right, not as a Government charity. This is an economically sound approach and consistent with our American principles and in line with the desire of every true American to maintain himself in decency and self-respect. This program provides insurance against the cost of medical care for practically everyone. It provides for sound administration with proper representation from those who pay the costs and receive the services. It would be administered with Federal, State, and local participation, with emphasis on local responsibility. While compulsory in terms of coverage and requirement for contributions, it preserves the freedom of individuals to choose their own doctors and respects the freedom of doctors and hospitals to accept or reject patients. We submit that of the three proposals this is the only practical one. It is practical because it has taken ito account all the many phases of the complex problem of providing medical care and services.

There are those who agree with the principle of comprehensive health insurance but who would tell us that it is impractical now because there are not enough trained professional personnel. This bill does not deny the need for training additional doctors and other medical personnel. The answer to those who say that we cannot have a health insurance program because of these shortages is found in title I, where an adequate program of Federal aid to medical education is provided. It meets the needs of the medical schools, the dental schools, the schools of dental hygiene, schools of nursing, schools of public health, and schools of engineering.

Another provision of this title provides direct assistance to qualified students training for service in the medical field. Since the costs of modern medical education are necessarily high, under present circumstances very few can enter the field except the sons and daughters of the rich. Students of medicine and allied fields should not be selected on the basis of the financial means of their parents. When this program has been in effect for some years we look forward to there being not only more doctors, but more doctors who understand the problems of working people, as some sons of workingmen would then have a chance to enter the profession.

There are others who say that the method of payment provided in a health-insurance program does not meet all of the problems, because there is much work to be done in the field of medical research. We have never claimed that health insurance alone meets all of the needs. The need for additional medical research in the diseases which so far have baffled even our advanced medical science is recognized. The answer to those who would have us wait for the further development of research is found in title II, where aid to such research is provided, through the setting up of continuously financed institutes of research in special fields.

The interrelationship of the various provisions of these two bills, H. R. 4312 and H. R. 4313, is illustrated by the direct relationship between titles III and VIII.

In March 1946, testifying on behalf of the American Federation of Labor before a congressional committee, I believe this one, Mr. Chairman, in support of the Hill-Burton Act, I presented the following statement:

> It is not only possible but entirely likely that the areas showing the greatest needs for health facilities will also be the areas where it will be most difficult to provide funds necessary for the operation of such facilities. We feel therefore that this program will be incomplete until there is some provision for funds for maintenance and operation.
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> The position of the American Federation of Labor is that the soundest method of providing funds for the operation of health facilities is through a national system of health insurance as proposed in President Truman's health message to Congress.

While notable progress has been made under the operation of the Hill-Burton Act toward meeting the need for more hospital facilities, we note that seldom has any prophecy been more clearly borne out than the one we made 3 years ago. The report presented to the Federal Hospital Advisory Council at its last meeting in November 1948 showed that the State plans which had been submitted under the act showed a need for 865,682 new hospital beds, almost doubling the number of approved beds in existing facilities. Under the program operation for the fiscal year 1948–49, 467 projects for general hospitals have been approved. These provide a total of 23,327 beds. Startling facts are revealed, however, by a study of the distribution of these projects by categories of need. These categories are set up under terms of the act in relation to priorities from A to F. Out of the 467 total approved projects only 253 or 54.2 percent were in A priority, corresponding to the areas found to be in greatest need. In terms of the number of beds in approved projects 10,691 or only 45.8 percent of beds are in the areas of greatest need as against 12,736 beds approved for areas of lesser need. In the State of Alabama, for example, there are nine approved projects but only one having an A priority and that a small one of 82 beds. This is 8.3 percent of the total of 981 beds approved for that State. Other States representing recognized areas of need show a similar type of distribution.

This again reveals the vicious cycle that is operating in the whole health field. Illness follows low income and is related to lack of facilities; low income in turn leads to a higher rate of illness and results in further lack of facilities. This vicious cycle must be broken by a concentrated united-front attack on the whole problem. The program of health insurance contemplated in title VII would provide the means for paying for the use of the facilities that are contemplated in title III. While we do not recommend that capital expenditures be made out of the insurance fund and this need is met by the liberalized proposal for grants in aid under title III, it is in title VII that the all important problem of funds for operation of these facilities is met.

Title IV of H. R. 4312 and 4313 again indicates the practical nature of this comprehensive program. In response to the recognized needs for additional personnel and facilities it provides grants or loans guaranteeing income to doctors and dentists and others who would practice in such areas. It meets such practical problems as the costs of travel for such persons and their families who are willing to respond to these needs. For those areas of sparse population mobile clinics and ambulance services are provided. There are also loans to supplement inadequate local funds for construction and grants for the maintenance of hospitals, group practice units, health centers, clinics, diagnostic and treatment centers. We recommended such a program in connection with the original Hill-Burton Act and experience under that act has likewise proven the practical need for such supplemental aid.

Part B of this title is in accord with our long-established policy that groups such as labor unions and cooperative organizations who establish adequate medical service plans should be encouraged and should be permitted to continue in operation as service agencies under a health-insurance program.

We are in full agreement with the provision of title V for we recognize that no health plan can be completely effective with only about 5 percent of the people of the country having available fully staffed local health units which meet the minimum standards recognized by experts in the field. Here again by and large it is the poorer areas of the Nation, where the health needs are the greatest, that are without proper faciilties and staff. In order to meet this problem the States must have financial assistance from the Federal Government.

We trust that the provisions of section 501 (b) in reference to occupational and other diseases constituting special health problems can be effectuated without encroachment on the proper functions of State Department of Labor. Should there be any doubt on this score we will be prepared to submit a clarifying amendment when your committee takes up the more detailed consideration of the separate titles.

We commend the enlarged program for aid to States for maternal, child health, and crippled children services, provided in title VI. The American Federation of Labor was one of the national organizations that sponsored the creation of the Children's Bureau. Through the years the position that the Children's Bureau has always taken with respect to the welfare and health of children has been one activated only by a concern that the conditions under which children live and grow shal be the best. The Bureau has shown courage and leadership in carrying out its functions in the interest of all children.

This position is supported by the following action of the sixty-seventh convention of the American Federation of Labor:

> We believe that all children regardless of race, residence, or family income have the right to whatever health and welfare services and medical care they need for wholesome growth and development and that it is the responsibility of the Federal Government to help the States and communities meet these requirements. We favor raising the amounts available for payments to the States to whatever sum is needed to meet the requirements of an adequate maternal and child-welfare program.

The American Federation of Labor fully supports H. R. 4312 and 4313 in their entirety. The program they represent is a fully rounded, carefully integrated program. We urge your committee to give this program your favorable consideration. There will be some temptation to recommend certain titles of these bills as noncontroversial. Yielding to such a piecemeal approach will not meet the urgent health problems of our people. We urge you to look at the many-sided problem in its entirety and recommend the adoption of the complete program which is before you and which represents years of thinking and planning.

Thank you, Mr. Chairman. That concludes my statement.

Mr. PRIEST. Mr. Cruikshank, we always appreciate your appearance before this committee. In the many times you have appeared here on various bills, you have always been very helpful.

Are there any questions by any members of the committee?

Mr. BIEMILLER. Mr. Chairman.

Mr. PRIEST. Mr. Biemiller.

Mr. BIEMILLER. I would like to just raise one question, which in part refers back to yesterday.

I believe, Mr. Cruikshank, you were here during most of the testimony yesterday.

Mr. CRUIKSHANK. Yes, sir; I was.

Mr. BIEMILLER. I believe you heard the attempt that was made by one of the witnesses yesterday who attacked the Committee for the Nation's Health. By reference and through overtones she pinned the Communist label on that organization.

I notice President William Green, of the American Federation of Labor, is honorary vice chairman of the Committee for the Nation's Health. Mr. Matthew Woll is a member of the executive committee or the board of directors.

Mr. Woll is chairman, is he not, of the social committee of the American Federation of Labor?

I wonder if you will just for a moment or two comment on the attitude of the American Federation of Labor on that.

Mr. CRUIKSHANK. I would be glad to do that. We were instrumental in forming the new, or the reformed, Committee for the Nation's Health several years ago, and at that time, as a matter of fact, some of the early organizational meetings took place in the executive council room of our hearquarters.

As the staff member in charge of social insurance for the federation, I kept both President Green and Chairman Woll informed of these developments, and they encouraged them and thought there was a definite place for a group of this kind, which would serve as a clearinghouse agency for the many organizations that were interested in health insurance. They supported the idea and evidenced their willingness to take part in it.

As I am sure you recognize, men in the responsible positions which they hold—and Mr. Woll also being located in New York City—cannot attend all of the meetings of the executive board and of the governing bodies of such an organization, and they have designated me, and the committee has accepted my serving, as an alternate member representing them on some of the executive committee meetings.

I reported to them consistently on the activities of the Committee for the Nation's Health and its composition, and they have continued their active support of it.

That does not mean that everything that is done by every organization or this organization has their complete approval, but we have deemed, on the basis of full reports which I have submitted, that it is a very useful organization and one which merits our continuing support.

It is interesting also to note that reference to the committee is made in the executive council's report of last August, which was, as I said, a report to the convention and a very brief report, but a complimentary one, on the work that they have done in this field.

Mr. Biemiller. And furthermore, in line with that same testimony, you will recall there was a chart presented that alleged a great plot under the leadership of Dr. Michael M. Davis and Dr. Isidore Sydney Falk.

I take it that the American Federation of Labor has reached its present position without any prodding by this so called Davis-Falk axis that we heard about yesterday.

Mr. Cruikshank. Well, as you will note in the testimony, our first resolution at the conventions of the American Federation of Labor was passed in 1938, and, incidentally, as I believe you are aware, that resolution was sponsored by the Wisconsin State Federation of Labor and was adopted by the convention of the American Federation of Labor.

Now, I do not believe that the Wisconsin Federation of Labor was activated by the so-called Falk-Davis axis, and I am sure that the various federation conventions which year after year have endorsed such resolutions in the conventions have not been activated by it. Certainly, anyone who knows the operation of the American Federation of Labor and its executive council who believes that they could be hoodwinked into adopting a position by some overzealous bureaucrat or overzealous reformers does not know the temper of the executive council of the American Federation of Labor. If those of you who have known people like our dear late departed Bob Watt, who for years represented the American Federation of Labor of the ILO, ever thought he was subject to communistic designs, they certainly did not know Bob.

I am sure, too, Mr. Meany, who is a member of our social security committee, secretary-treasurer of the American Federation of Labor, and now in Geneva attending a meeting of the governing body of the ILO, would be quite surprised to find that he had unwittingly become a tool of the so-called Bismarck communistic design, which is a very peculiar thing.

Mr. Sadowski. I think it went back to 1799.

Mr. Cruikshank. I think that is right. Not to be facetious, I am sure that the American Federation of Labor is aware of these forces. We know, too, of course, that the Communists are very prone to take good causes and subvert them to their own evil designs. They are great ones to try to claim sponsorship for good social causes, not that they want to see them accomplished, but that they wish to exploit the needs and desires of people to stir up this discontent.

That is always a problem. It is a problem in any social legislation. The Communists espouse housing legislation and they espoused the Minimum Wage Act and everything that comes along to try to give the kiss of death. We do not believe in letting Communists tell us what to do or what not to do. We do not believe in dropping a program simply because the Communists decide to wrap themselves around it and espouse it.

Mr. Biemiller. I share the point of view that you expressed a moment ago, Mr. Chairman, that we are always pleased to have Mr. Cruikshank's testimony before committees of the Congress. We know that the organization which he represents has a long and honorable record in our society, that it has been in the forefront of the fight against the growth of communism in the United States.

I am happy to have the testimony which, coupled with that given by Mr. Carey yesterday, I think very effectively disposes of any illusions which might have been created by the loose charges which were thrown before this committee yesterday that alleged Communists or foreign inspiration were responsible for the bills now before this committee.

Thank you very much.

Mr. O'Hara. Mr. Cruikshank, I gathered from your testimony that possibly in some of these group organizations there have been Communists who have wormed their way into the organizations, voluntary organizations, or organizations espousing social or health legislation or other legislation. Is that not true?

Mr. Cruikshank. Yes; I think that that is true.

Mr. O'Hara. It is probably wise for labor organizations and for the Congress to be advised from time to time as to who some of these individuals may be; is that not true?

Mr. Cruikshank. Yes; that is true. We have to be careful that we do it on a careful and scientific basis, or we unwittingly become the tools of the very groups to which we are opposed.

Mr. O'Hara. Mr. Cruikshank, have you made any estimates of the cost of the various sections of the bill in your organization?

Mr. Cruikshank. No, sir; we have not gone into the costs of all of the various proposals. We have some estimates on the costs, particularly of title 7.

Mr. O'Hara. We will start, then, with Title 1, Education of Health Personnel. Have you made any estimate on that?

Mr. Cruikshank. No, sir; we have not.

Mr. O'Hara. Title 2, Medical Research?

Mr. Cruikshank. No, sir. Of course, there are limits on the appropriations there which themselves, while they do not pretend to meet the entire problem, this bill itself in terms of the costs contained in the bill is set by the limits on the appropriations.

Mr. O'Hara. And title 3, Hospital Surveys?

Mr. Cruikshank. The same is true there. It is a $300,000,000 program.

Mr. O'Hara. And title 4?

Mr. Cruikshank. The same limitations on the authorized appropriations, that holds true there.

Mr. O'Hara. And title 5?

Mr. Cruikshank. I think the comment holds as to that, also.

Mr. O'Hara. Title 6?

Mr. Cruikshank. The same is true there, I believe.

Mr. O'Hara. As to title 7, what are your estimates of the cost of that paragraph?

Mr. Cruikshank. Figuring the wages covered on a $4,800 limitation in 1950, there would be brought under the program wages totaling about $140,000,000,000 on the compulsory basis, and then the voluntary State and local that could be brought in by compact would add another 9 or 10 billion dollars, which would make the total wage base roughly $150,000,000,000.

Now, 3 percent of that would bring in revenue of about 4.5 billion dollars into the program. That is the 3 percent contemplated contribution rate. The present annual out-of-pocket expenditures for medical care are about $7,000,000. Drugs, medicine, and dental that are not medically covered by the bill is about 1.25 billion dollars of that, which leaves about 5.75 billion dollars.

A 4 percent of pay roll would bring in, of course, $6,000,000,000, but about 70 percent of the total of the $7,000,000,000 now annual out-of-pocket payment, 70 percent of that would be absorbed by the health insurance services established in title 7, which is about 4.9 to 5 billion dollars.

Very frankly, however, we contemplate that there would be an increase in the load because people would get medical care and services who do not receive them at present, and who are denied them. There would be an increase in the demand, which would probably raise the total cost of insured items to 5.25 or 6 billion dollars.

Mr. O'Hara. What would be the difference between that which was by way of contribution from the employer, and employee, and that which would be contributed by general taxation?

Mr. Cruikshank. If our low estimate is sound, 5.25 billion dollars, then there would be three-quarters of a billion dollars that would need to come from general revenues. If our high-cost estimate would be sound, it would be 1.5 billion dollars. It would be between three-quarters and 1.5 billion dollars that would need to come from the general revenues of the Government.

Mr. O'Hara. I think it is true, Mr. Cruikshank, that the estimated costs of the British plan and the actual cost of the plan has been considerably at variance, is that not true? The cost has been much higher than estimated.

Mr. Cruikshank. I think we also need to make a reservation which you may well have in mind, when we compare the British system with that contemplated here. They do not have a health-insurance system, but with that notation, it is true that they did underestimate their costs, and they underestimated the cost because they were not aware of the tremendous backlog of medical care that was needed on the part of the population, particularly with respect to care for teeth and for eyeglasses and for such items as that. They did not know that there were hundreds of thousands of people in the population who were not reading because they did not have glasses. They did not realize, for example, as one doctor pointed out in a report, that mothers were bringing their chilren to the doctor's office and going out without getting care which they needed themselves. That is a normal human thing to do, but when there is a certain limit on the amount of money in a family budget, mothers would see that their children got care, but they were postponing or doing without the medical care themselves.

Now, those are certain subjective items which are always difficult to appraise in advance. We do not believe that we have that extensive a problem in medical care in this country, except in some areas.

Mr. O'Hara. Would this include "toupee to corn plaster" that the British have?

Mr. Cruikshank. I am glad that you mentioned that, because I am glad to have on the record that it has an element of humor in it. It has an element of humor in it that people like to talk about, but it is significant to recall that there is much talk about the toupee program in Great Britain. A man can get a toupee under the system only if it is written on a prescription by a doctor as to something which he needs in order to protect his health. It is not something which he thinks that he would get along better with, perhaps, if he had it.

But seriously, those toupees have been much talked about, and there has been a good bit of laughter over them. It is important to note that they are available only on a doctor's prescription, when the doctor certifies that they are necessary for the man's health.

Mr. O'Hara. Would that be included in this bill, do you think?

Mr. Cruikshank. This bill does not have provision for that sort of thing.

Mr. O'Hara. I just wanted to make sure.

As a matter of reality, of course, there is a limitation here in title 7 to the employer and employee relationship, of the coverage.

Mr. Cruikshank. Not the way I understand it. First the employees and their dependents, and then there are the self-employed that are covered under the bill, and then there is also a provision for those who are in the dependent status, certified as such by the local office. There are the aged, the recipients of old-age survivors' insurance benefits, and others.

Mr. O'Hara. Your estimates of the benefits are based solely on the employee relationship; is that not true?

Mr. Cruikshank. No; on the estimate of pay-roll income. I based it on the employee relationship and on the income from the self-employed.

Mr. O'Hara. Not on the unemployed?

Mr. Cruikshank. No, sir.

Mr. O'Hara. Your estimates as to cost would not include a considerable cost which would be by the unemployed? Is that not true?

Mr. Cruikshank. Estimates of cost were based on the present expenditures for medical care.

Mr. O'Hara. How was that estimated?

Mr. Cruikshank. Various studies have been made by the Department of Commerce and other responsible agencies on the total expenditures for medical care in their family income and expenditure studies. That has been done as well by private groups. That study indicates that about $7,000,000,000 is being spent and it is important to remember that, because many of these figures that are presented have indicated that there would be an additional load on the population; there would not be an additional load, it is not a net increase, but it is simply a shift in the method of payment. There are also certain hidden costs that we cannot estimate, but which we know exist.

For instance, a person today who is without protection of an insurance program or an adequate insurance program confronted by the necessity of paying a high hospital bill often has to go to some of these private loan agencies where he will pay 36 or 40 percent interest on money that is borrowed. He sometimes has to pay that for several years.

Now, no study of the cost of medical care has attempted to include that, but we do know that it is there. Under a health-insurance program, those costs on low- and middle-income people would be entirely eliminated.

Mr. O'Hara. Is it true, Mr. Cruikshank, that you can estimate with any accuracy, speaning of title 7 now, what would actuarially be the cost of this program? Is it not true that it is almost impossible to estimate actually and completely what the cost would be, what the worker would pay, and what the Government would pay?

Mr. CRUIKSHANK. Mr. O'Hara, that is true when we come down to the last decimal point. We do not have figures in the health field now comparable to life insurance actuarial studies, for example. That is true with a number of social-security insurances. You cannot estimate unemployment, for example. We insure against it, however. We did not have comparable actuarial figures in 1935 on the pay-roll base for old-age and survivors insurance or upon retirement. Retirement is also a fluctuating value, or a fluctuating figure, and the estimates that were made by the most qualified experts from our universities and other institutions, and from Government, in 1935 on retirement and their projections of wage structures and so forth, were considerably off.

But even though they were considerably off, they were near enough to the facts so that a sound and workable program could be built on them. We do not need to have figures right down to the last decimal point. We need to do the wisest planning that we can do, but recognizing then that there will be an expected variation from those projected figures. We should go ahead on the best planning that we are capable of doing.

Mr. O'HARA. I appreciate your fairness, but my time has elapsed in which I am entitled to question you at this time. Thank you.

Mr. WILSON. Mr. Cruikshank, on page 5 of your statement you set forth very briefly résumés of the reports submitted to the November 1948 meeting of the Federal Hospital Advisory Council as related to the equivalent beds and hospitals. Is that a published report?

Mr. CRUIKSHANK. I am not sure that it is, Mr. Congressman.

Mr. WILSON. Do you have that report available here?

Mr. CRUIKSHANK. I believe I would be allowed to submit it. I happen to be a member of that Advisory Council and I raised this question at the meeting of the Advisory Council. The material was not marked "confidential," and I am sure the Surgeon General would be glad to furnish the committee with a complete report.

Mr. WILSON. I would like to ask permission that it be made a part of the record, because I think it is important to show whether there is a justification for increased hospital facilities.

Mr. PRIEST. Without objection, it will be made a part of the record, if furnished by the Surgeon General. I am sure that that can be taken care of.

(The document is as follows:)

FEDERAL SECURITY AGENCY,
PUBLIC HEALTH SERVICE,
Washington, D. C., June 15, 1949.

Hon. J. PERCY PRIEST,
Chairman, Subcommittee on Public Health, Science, and Commerce of the House Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

MY DEAR MR. PRIEST: In testifying before your subcommittee on Tuesday, June 7, Mr. Cruikshank, representing the American Federation of Labor, referred to a report which the Public Health Service presented to the Federal Hospital Advisory Council in November 1948. I understand that a request was made at that time that a copy of this report be inserted in the record of the hearing. I am, therefore, enclosing a copy of the relevant portion of the report which you may use if you so desire.

I should like to point out, however, that we plan to submit still more recent data on hospital bed needs in connection with forthcoming hearings before your subcommittee on title III of H. R. 4313 and H. R. 4312, and related bills. You might, therefore, prefer to defer the inclusion of this statistical material in the record until that time.

In Dr. Scheele's absence from the country I hope you will call on me for any assistance which we in the Public Health Service can provide to you or your committee.

Sincerely yours,

W. P. DEARING,
Acting Surgeon General.

NUMBER OF EXISTING HOSPITAL BEDS AND ADDITIONAL BEDS NEEDED BY TYPE OF SERVICE

The State plans for hospital construction submitted under the Federal Hospital Survey and Construction Act show that the United States and Territories (exclusive of Nevada which has not yet submitted a plan) have a total of 1,024,286 hospital beds. Of these 879,377 are considered by the State and Territorial agencies to be acceptable, the remainder being considered unacceptable because of obsolescence, unsuitable design, fire hazard, or other failure to meet the standards set up by the agencies administering the program.

On the basis of standards set forth in the Federal Act, the States and Territories estimate that an additional 898,132 beds are needed.

According to the State plans, as of October 25, 1948, the Nation has a total of 397,206 acceptable beds for general hospital care; 255,575 additional beds are estimated to be necessary. There are a total of 381,627 acceptable beds in mental hospitals (beds in institutions for mental deficiency and epileptics are not considered in the State plans since these institutions are regarded as providing primarily domiciliary type of care) and 310,523 additional beds are estimated to be required. For tuberculosis hospital care the Nation has 72,052 acceptable beds and needs 83,715 more. Chronic hospitals have 28,492 beds and it is estimated that 248,319 additional beds would be needed to give adequate care.

The States and Territories estimated their needs for general hospital beds on the basis of 4½ to 5½ beds per 1,000 population depending on the density of the population of the State. Needs for mental beds were estimated on the basis of 5 beds per 1,000 population, for tuberculosis beds on the basis of 2½ beds per annual death from tuberculosis, and for chronic beds on the basis of 2 beds per 1,000 population.

OFFICE OF SPECIAL SERVICES,
Division of Hospital Facilities.

NOVEMBER 4, 1948.

Number of existing hospital beds and additional beds needed by type of service—Reported in official State plans for hospital construction as of Oct. 25, 1948—Hospital Survey and Construction Act [1]

State	Total			General			Mental			Tuberculosis			Chronic disease		
	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]
	Total	Acceptable [2]		Total	Acceptable [2]		Total	Acceptable [2]		Total	Acceptable [2]		Total	Acceptable [2]	
Total United States and Territories [4]	1,024,286	879,377	898,132	474,237	397,206	255,575	428,931	381,627	310,523	84,957	72,050	83,715	36,161	28,492	248,319
Total United States [4]	1,008,403	867,701	865,682	464,191	390,450	250,175	426,773	379,620	299,145	81,496	69,243	73,293	35,943	28,388	243,069
Alabama	12,901	11,185	23,647	6,593	4,937	7,340	5,729	5,729	7,912	579	519	2,939	------	------	5,456
Arizona	4,186	4,140	6,316	2,521	2,475	1,218	1,250	1,250	1,995	396	396	1,824	19	19	1,279
Arkansas	10,592	6,847	17,109	4,445	3,290	5,194	4,796	2,206	7,181	1,351	1,351	979	------	------	3,755
California	74,284	61,833	50,375	32,810	27,858	16,378	29,408	28,310	13,386	6,784	2,231	7,367	5,282	3,434	13,244
Colorado	11,429	10,378	4,298	4,860	4,093	1,459	5,268	5,204	96	1,270	1,050	654	31	31	2,089
Connecticut	16,240	16,056	8,983	6,774	6,590	2,616	7,280	7,280	2,800	1,721	1,721	------	465	465	3,567
Delaware	2,856	2,744	1,036	1,173	1,161	253	1,254	1,154	311	193	193	122	236	236	350
District of Columbia	10,765	5,900	4,965	4,112	2,111	1,557	5,161	2,567	1,509	1,177	1,052	439	315	170	1,460
Florida	14,115	13,377	14,666	6,762	6,570	3,553	5,842	5,842	5,401	1,018	515	1,665	493	450	4,047
Georgia	19,061	18,607	20,204	7,337	6,883	7,015	9,351	9,351	6,089	1,288	1,288	2,009	1,085	1,085	5,091
Idaho	2,558	2,094	4,047	1,619	1,155	1,443	721	721	1,640	55	55	182	163	163	782
Illinois	55,199	41,264	53,943	27,952	22,955	11,707	22,289	13,351	24,390	4,570	4,570	3,138	388	388	14,708
Indiana	19,958	16,682	25,416.	9,714	7,203	8,130	8,386	8,264	8,673	1,779	1,136	1,917	79	79	6,696
Iowa	15,996	10,474	19,799	9,119	6,689	4,831	6,086	3,113	9,582	791	672	308	------	------	5,078
Kansas	10,985	10,353	11,480	5,741	5,109	3,163	4,786	4,786	4,179	458	458	552	------	------	3,586
Kentucky	15,185	14,349	19,658	6,220	5,733	6,055	7,135	7,052	5,551	1,607	1,564	3,011	223	------	5,041
Louisiana	16,231	12,639	19,695	8,495	7,110	4,669	6,796	4,620	7,723	940	909	2,366	------	------	4,937
Maine	7,587	6,208	4,580	3,035	1,656	2,277	3,856	3,856	514	526	526	211	170	170	1,578
Maryland	18,593	17,249	9,208	6,736	6,515	2,639	7,453	7,278	2,812	1,883	1,743	1,434	2,521	1,713	2,323
Massachusetts	45,237	43,712	16,559	19,341	17,906	5,981	21,123	21,102	1,738	3,673	3,604	804	1,100	1,100	8,036
Michigan	38,927	26,216	48,340	18,119	14,011	13,769	15,171	7,522	22,728	4,645	3,811	615	992	872	11,228
Minnesota	21,369	18,418	17,299	11,403	9,165	4,967	7,644	7,185	6,905	1,924	1,859	------	398	209	5,427
Mississippi	9,915	8,336	17,004	4,829	3,345	5,632	4,408	4,408	5,542	541	458	1,975	137	125	3,855
Missouri	29,090	28,113	20,682	14,319	13,342	4,934	11,885	11,885	6,995	1,805	1,805	2,282	1,081	1,081	6,471
Montana	4,928	4,351	2,527	2,893	2,316	727	1,800	1,800	584	235	235	262	------	------	954
Nebraska	11,867	10,496	5,448	5,457	4,086	2,426	6,210	6,210	168	200	200	303	------	------	2,551
New Hampshire	4,576	4,300	1,975	2,204	1,928	446	1,985	1,985	580	189	189	121	198	198	828
New Jersey	36,481	36,456	17,273	16,675	16,650	3,970	14,145	14,145	6,940	3,359	3,359	231	2,302	2,302	6,132
New Mexico	2,698	2,552	5,141	1,356	1,210	1,800	1,018	1,018	1,658	284	284	653	40	40	1,030
New York	138,212	125,316	49,565	56,942	44,046	18,670	64,511	64,511	4,728	11,594	11,594	3,636	5,165	5,165	22,531
North Carolina	22,095	19,439	26,550	9,798	8,003	9,488	10,123	9,446	8,417	2,014	1,830	1,660	160	160	6,985
North Dakota	4,919	4,829	2,510	2,376	2,286	1,141	2,160	2,160	438	275	275	------	108	108	931

See footnotes at end of table.

Number of existing hospital beds and additional beds needed by type of service—Reported in official State plans for hospital construction as of Oct. 25, 1948—Hospital Survey and Construction Act [1]—Continued

State	Total			General			Mental			Tuberculosis			Chronic disease		
	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]	Existing		Additional beds needed [3]
	Total	Acceptable [2]		Total	Acceptable [2]		Total	Acceptable [2]		Total	Acceptable [2]		Total	Acceptable [2]	
Ohio	43, 970	38, 134	55, 254	21, 635	19, 110	14, 682	18, 428	16, 239	21, 256	3, 298	2, 785	4, 318	609	--------	14, 998
Oklahoma	14, 507	14, 096	12, 513	7, 389	6, 978	2, 899	5, 932	5, 932	4, 240	1, 186	1, 186	1, 305	--------	--------	4, 069
Oregon	9, 328	8, 677	8, 842	4, 453	3, 886	2, 733	4, 299	4, 299	2, 964	576	492	240	--------	--------	2, 905
Pennsylvania	71, 819	60, 591	64, 797	35, 375	27, 268	17, 751	29, 555	28, 818	21, 203	5, 647	3, 609	6, 731	1, 242	896	19, 112
Rhode Island	7, 084	6, 954	2, 217	1, 981	1, 851	1, 459	3, 282	3, 282	395	629	629	84	1, 192	1, 192	279
South Carolina	9, 162	8, 621	15, 143	4, 785	4, 244	4, 384	3, 414	3, 414	6, 001	903	903	1, 052	60	60	3, 706
South Dakota	4, 698	4, 253	3, 164	2, 618	2, 173	978	1, 888	1, 888	836	192	192	261	--------	--------	1, 089
Tennessee	15, 087	14, 912	23, 218	6, 890	6, 715	6, 346	6, 808	6, 808	7, 354	1, 142	1, 142	4, 100	247	247	5, 418
Texas	36, 404	34, 761	54, 591	18, 678	17, 158	14, 778	13, 631	13, 631	21, 166	2, 124	2, 103	6, 597	1, 971	1, 869	12, 050
Utah	3, 458	3, 220	4, 047	2, 242	2, 004	955	1, 120	1, 120	1, 839	96	96	69	--------	--------	1, 184
Vermont	3, 420	3, 027	1, 651	1, 261	868	770	2, 012	2, 012	--------	147	147	153	--------	--------	728
Virginia	18, 339	11, 581	24, 571	7, 594	6, 813	5, 932	9, 234	3, 848	10, 202	1, 511	920	2, 817	--------	--------	5, 620
Washington	19, 903	16, 509	7, 829	7, 890	7, 398	1, 768	5, 077	4, 341	5, 428	1, 317	833	633	5, 619	3, 937	--------
West Virginia	10, 902	7, 893	14, 121	6, 329	4, 671	3, 308	3, 252	2, 201	6, 384	1, 321	1, 021	995	--------	--------	3, 434
Wisconsin	29, 401	17, 871	21, 569	12, 243	10, 026	5, 374	13, 105	5, 770	10, 043	2, 201	1, 651	251	1, 852	424	5, 901
Wyoming	1, 886	1, 688	1, 857	1, 098	900	610	706	706	669	82	82	28	--------	--------	550
Total Territories	15, 883	11, 676	32, 450	10, 046	6, 756	5, 400	2, 158	2, 007	11, 378	3, 461	2, 809	10, 422	218	104	5, 250
Alaska	630	287	1, 747	449	127	362	--------	--------	438	137	116	816	44	44	131
Hawaii	4, 518	1, 912	4, 774	2, 547	784	1, 573	809	689	1, 931	1, 048	439	222	114	--------	1, 048
Puerto Rico	10, 385	9, 477	25, 561	6, 753	5, 845	3, 329	1, 318	1, 318	8, 875	2, 254	2, 254	9, 339	60	60	4, 018
Virgin Islands	350	--------	368	297	--------	136	31	--------	134	22	--------	45	--------	--------	53

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes data for Nevada, which has not submitted a plan.

[2] Number of existing beds which are reported as acceptable; excludes beds classified as nonacceptable by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[3] Additional beds needed as determined on the basis of ratios prescribed by the Hospital Survey and Construction Act.

[4] Excludes Nevada, which has not submitted a State plan.

Source: Division of Hospital Facilities, Oct. 25, 1948.

TABLE I.—*Total number of hospital beds needed, existing, and additional needs—Deported in official State plans for hospital construction as of Oct. 25, 1948* [1]

ALL HOSPITAL BEDS [2]

State	Civilian population [3]	Total beds needed [4]	Existing		Additional beds needed
			Total	Acceptable [5]	
Total, United States and Territories [6]	139, 686, 754	1, 777, 023	1, 024, 286	879, 377	898, 132
Total, United States [6]	137, 007, 535	1, 732, 897	1, 008, 403	867, 701	865, 682
Alabama	2, 728, 120	34, 832	12, 901	11, 185	23, 647
Arizona	648, 400	10, 456	4, 186	4, 140	6, 316
Arkansas	1, 877, 409	23, 956	10, 592	6, 847	17, 109
California	9, 605, 000	112, 208	74, 284	61, 833	50, 375
Colorado	1, 060, 239	14, 676	11, 429	10, 378	4, 298
Connecticut	2, 016, 000	24, 810	16, 240	16, 056	8, 983
Delaware	293, 000	3, 780	2, 856	2, 744	1, 036
District of Columbia	815, 195	10, 865	10, 765	5, 900	4, 965
Florida	2, 248, 595	28, 043	14, 115	13, 377	14, 666
Georgia	3, 088, 393	38, 811	19, 061	18, 607	20, 204
Idaho	472, 314	6, 141	2, 558	2, 094	4, 047
Illinois	7, 548, 109	95, 207	55, 199	41, 264	53, 943
Indiana	3, 387, 463	42, 098	19, 958	16, 682	25, 416
Iowa	2, 539, 075	30, 273	15, 996	10, 474	19, 799
Kansas	1, 794, 559	21, 833	10, 985	10, 353	11, 480
Kentucky	2, 520, 537	34, 007	15, 185	14, 349	19, 658
Louisiana	2, 468, 596	32, 334	16, 231	12, 639	19, 695
Maine	874, 038	10, 788	7, 587	6, 208	4, 580
Maryland	1, 983, 697	26, 457	18, 593	17, 249	9, 208
Massachusetts	4, 566, 800	60, 271	45, 237	43, 712	16, 559
Michigan	6, 049, 897	74, 556	38, 927	26, 216	48, 340
Minnesota	2, 817, 972	35, 696	21, 369	18, 418	17, 299
Mississippi	1, 990, 073	25, 340	9, 915	8, 336	17, 004
Missouri	3, 776, 250	48, 795	29, 090	28, 113	20, 682
Montana	492, 240	6, 878	4, 928	4, 351	2, 527
Nebraska	1, 275, 713	15, 944	11, 867	10, 496	5, 448
New Hampshire	497, 812	6, 275	4, 576	4, 300	1, 975
New Jersey	4, 217, 108	53, 729	36, 481	36, 456	17, 273
New Mexico	535, 220	7, 693	2, 698	2, 552	5, 141
New York	13, 847, 903	174, 881	138, 212	125, 316	49, 565
North Carolina	3, 572, 631	45, 989	22, 095	19, 439	26, 550
North Dakota	519, 709	7, 324	4, 919	4, 829	2, 510
Ohio	7, 498, 400	93, 388	43, 970	38, 134	55, 254
Oklahoma	2, 034, 460	26, 609	14, 507	14, 096	12, 513
Oregon	1, 452, 618	17, 519	9, 328	8, 677	8, 842
Pennsylvania	10, 004, 220	125, 388	71, 819	60, 591	64, 797
Rhode Island	735, 344	9, 171	7, 084	6, 954	2, 217
South Carolina	1, 883, 106	23, 764	9, 162	8, 621	15, 143
South Dakota	544, 866	7, 417	4, 698	4, 253	3, 164
Tennessee	2, 832, 480	38, 130	15, 087	14, 912	23, 218
Texas	7, 004, 100	89, 352	36, 404	34, 761	54, 591
Utah	591, 910	7, 267	3, 458	3, 220	4, 047
Vermont	364, 000	4, 486	3, 420	3, 027	1, 651
Virginia	2, 810, 278	36, 152	18, 339	11, 581	24, 571
Washington	1, 953, 725	24, 309	19, 903	16, 509	7, 829
West Virginia	1, 732, 355	22, 014	10, 902	7, 893	14, 121
Wisconsin	3, 162, 606	39, 440	29, 401	17, 871	21, 569
Wyoming	275, 000	3, 545	1, 886	1, 688	1, 857
Total, Territories	2, 679, 219	44, 126	15, 883	11, 676	32, 450
Alaska	87, 631	2, 034	630	287	1, 747
Hawaii	523, 802	6, 686	4, 518	1, 912	4, 774
Puerto Rico	2, 038, 628	35, 038	10, 385	9, 477	25, 561
Virgin Islands	29, 158	368	350	------------	368

[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes general, mental, tuberculosis, and chronic hospital beds.

[3] Total civilian population as reported in the State plans.

[4] Total beds needed as calculated on the basis of ratios prescribed by the act; total beds needed does not equal sum of existing acceptable plus additional needs in those States where existing beds exceed the number allowable on the basis of the State ratios.

[5] Number of existing beds which are reported as acceptable; excludes beds classified as nonacceptable by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[6] Excludes Nevada, which has not submitted a plan.

Source: Division of Hospital Facilities, Oct. 25 1948.

TABLE II.—*Total number of hospital beds needed, existing, and additional needs—Reported in official State plans for hospital construction as of Oct. 25, 1948* [1]

GENERAL BEDS [2]

State	Total beds needed [3]	Existing beds			Additional beds needed
		Total	Acceptable [4]		
			Number	Per 1,000 population	
Total United States and Territories [5]	652, 781	474, 237	397, 206	2. 8	255, 575
Total United States [5]	640, 625	464, 191	390, 450	2. 8	250, 175
Alabama	12, 277	6, 593	4, 937	1. 8	7, 340
Arizona	3, 693	2, 521	2, 475	3. 8	1, 218
Arkansas	8, 484	4, 445	3, 290	1. 8	5, 194
California	44, 236	32, 810	27, 858	2. 9	16, 378
Colorado	5, 552	4, 860	4, 093	3. 9	1, 459
Connecticut	9, 206	6, 774	6, 590	3. 3	2, 616
Delaware	1, 414	1, 173	1, 161	4. 0	253
District of Columbia	3, 668	4, 112	2, 111	2. 6	1, 557
Florida	10, 123	6, 762	6, 570	2. 9	3, 553
Georgia	13, 898	7, 337	6, 883	2. 2	7, 105
Idaho	2, 598	1, 619	1, 155	2. 4	1, 443
Illinois	34, 662	27, 952	22, 955	3. 0	11, 707
Indiana	15, 333	9, 714	7, 203	2. 1	8, 130
Iowa	11, 520	9, 119	6, 689	2. 6	4, 831
Kansas	8, 272	5, 741	5, 109	2. 8	3, 163
Kentucky	11, 788	6, 220	5, 733	2. 3	6, 055
Louisiana	11, 779	8, 495	7, 110	2. 9	4, 669
Maine	3, 933	3, 035	1, 656	1. 9	2, 277
Maryland	9, 154	6, 736	6, 515	3. 3	2, 639
Massachusetts	23, 887	19, 341	17, 906	3. 9	5, 981
Michigan	27, 780	18, 119	14, 011	2. 3	13, 769
Minnesota	14, 132	11, 403	9, 165	3. 3	4, 967
Mississippi	8, 977	4, 829	3, 345	1. 7	5, 632
Missouri	18, 276	14, 319	13, 342	3. 5	4, 934
Montana	3, 043	2, 893	2, 316	4. 7	727
Nebraska	6, 512	5, 457	4, 086	3. 2	2, 426
New Hampshire	2, 374	2, 204	1, 928	3. 9	446
New Jersey	20, 620	16, 675	16, 650	3. 9	3, 970
New Mexico	3, 010	1, 356	1, 210	2. 3	1, 800
New York	62, 716	56, 942	44, 046	3. 2	18, 670
North Carolina	17, 491	9, 798	8, 003	2. 2	9, 488
North Dakota	3, 427	2, 376	2, 286	4. 4	1, 141
Ohio	33, 792	21, 635	19, 110	2. 5	14, 682
Oklahoma	9, 877	7, 389	6, 978	3. 4	2, 899
Oregon	6, 619	4, 453	3, 886	2. 7	2, 733
Pennsylvania	45, 019	35, 375	27, 268	2. 7	17, 751
Rhode Island	3, 310	1, 981	1, 851	2. 5	1, 459
South Carolina	8, 628	4, 785	4, 244	2. 3	4, 384
South Dakota	3, 151	2, 618	2, 173	4. 0	978
Tennessee	13, 061	6, 890	6, 715	2. 4	6, 346
Texas	31, 936	18, 678	17, 158	2. 4	14, 778
Utah	2, 959	2, 242	2, 004	3. 4	955
Vermont	1, 638	1, 261	868	2. 4	770
Virginia	12, 745	7, 594	6, 813	2. 4	5, 932
Washington	9, 166	7, 890	7, 398	3. 8	1, 768
West Virginia	7, 979	6, 329	4, 671	2. 7	3, 308
Wisconsin	15, 400	12, 243	10, 026	3. 2	5, 374
Wyoming	1, 510	1, 098	900	3. 3	610
Total Territories	12, 156	10, 046	6, 756	2. 5	5, 400
Alaska	489	449	127	1. 4	362
Hawaii	2, 357	2, 547	784	1. 5	1, 573
Puerto Rico	9, 174	6, 753	5, 845	2. 9	3, 329
Virgin Islands	136	297	----------	----------	136

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals planned for the care and treatment of acute conditions and specialized types of cases.

[3] Total beds needed as calculated on the basis of ratios prescribed by the act.

[4] Number of existing beds which are reported as acceptable; excludes beds classified as nonacceptable by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[5] Excludes Nevada, which has not submitted a plan.

Source: Division of Hospital Facilities, Oct. 25, 1948.

TABLE III.—*Total number of hospital beds needed, existing, and additional needs—Reported in official State plans for hospital construction—As of Oct. 25, 1948* [1]

MENTAL BEDS [2]

State	Total beds needed [3]	Existing beds			Additional beds needed
		Total	Acceptable [4]		
			Number	Per 1,000 population	
Total United States and Territories [5]	[6] 691, 958	428, 931	381, 627	2. 8	310, 523
Total United States [5]	[6] 678, 573	426, 773	379, 620	2. 8	299, 145
Alabama	13, 641	5, 729	5, 729	2. 1	7, 912
Arizona	3, 245	1, 250	1, 250	1. 9	1, 995
Arkansas	9, 387	4, 796	2, 206	1. 2	7, 181
California	41, 696	29, 408	28, 310	2. 9	13, 386
Colorado	5, 300	5, 268	5, 204	4. 9	96
Connecticut	10, 080	7, 280	7, 280	3. 6	2, 810
Delaware	1, 465	1, 254	1, 154	3. 9	311
District of Columbia	4, 076	5, 161	2, 567	3. 1	1, 509
Florida	11, 243	5, 842	5, 842	2. 6	5, 401
Georgia	15, 440	9, 351	9, 351	3. 0	6, 089
Idaho	2, 361	721	721	1. 5	1, 640
Illinois	37, 741	22, 289	13, 351	1. 8	24, 390
Indiana	16, 937	8, 386	8, 264	2. 4	8, 673
Iowa	12, 695	6, 086	3, 113	1. 2	9, 582
Kansas	8, 965	4, 786	4, 786	2. 7	4, 179
Kentucky	12, 603	7, 135	7, 052	2. 8	5, 551
Louisiana	12, 343	6, 796	4, 620	1. 9	7, 723
Maine	4, 370	3, 856	3, 856	4. 4	514
Maryland	10, 090	7, 453	7, 278	3. 7	2, 812
Massachusetts	22, 840	21, 123	21, 102	4. 6	1, 738
Michigan	30, 250	15, 171	7, 522	1. 2	22, 728
Minnesota	14, 090	7, 644	7, 185	2. 5	6, 905
Mississippi	9, 950	4, 408	4, 408	2. 2	5, 542
Missouri	18, 880	11, 885	11, 885	3. 1	6, 995
Montana	2, 384	1, 800	1, 800	3. 7	584
Nebraska	6, 378	6, 210	6, 210	4. 9	168
New Hampshire	2, 565	1, 985	1, 985	4. 0	580
New Jersey	21, 085	14, 145	14, 145	3. 4	6, 940
New Mexico	2, 676	1, 018	1, 018	1. 9	1, 658
New York	69, 239	64, 511	64, 511	4. 7	4, 728
North Carolina	17, 863	10, 123	9, 446	2. 6	8, 417
North Dakota	2, 598	2, 160	2, 160	4. 2	438
Ohio	37, 495	18, 428	16, 239	2. 2	21, 256
Oklahoma	10, 172	5, 932	5, 932	2. 9	4, 240
Oregon	7, 263	4, 299	4, 299	3. 0	2, 964
Pennsylvania	50, 021	29, 555	28, 818	2. 9	21, 203
Rhode Island	3, 677	3, 282	3, 282	4. 5	395
South Carolina	9, 415	3, 414	3, 414	1. 8	6, 001
South Dakota	2, 724	1, 888	1, 888	3. 5	836
Tennessee	14, 162	6, 808	6, 808	2. 4	7, 354
Texas	34, 797	13, 631	13, 631	1. 9	21, 166
Utah	2, 959	1, 120	1, 120	1. 9	1, 839
Vermont	[6] 1, 820	2, 012	2, 012	5. 5	-----------
Virginia	14, 050	9, 234	3, 848	1. 4	10, 202
Washington	9, 769	5, 077	4, 341	2. 2	5, 428
West Virginia	8, 585	3, 252	2, 201	1. 3	6, 384
Wisconsin	15, 813	13, 105	5, 770	1. 8	10, 043
Wyoming	1, 375	706	706	2. 6	669
Total Territories	13, 385	2, 158	2, 007	. 7	11, 378
Alaska	438	-----------	-----------	-----------	438
Hawaii	2, 620	809	689	1. 3	1, 931
Puerto Rico	10, 193	1, 318	1, 318	. 6	8, 875
Virgin Islands	134	31	-----------	-----------	134

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals for the diagnosis and treatment of nervous and mental illness but excluding beds in institutions for the feeble-mineded and epileptics.

[3] Total beds needed as calculated on the basis of 5 beds per thousand population.

[4] Number of existing beds which are reported as acceptable; excludes beds classified as nonacceptable by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[5] Excludes Nevada, which has not submitted a plan.

[6] Total beds needed does not equal the sum of existing acceptable plus additional needed in Vermont, where existing beds exceed the number allowable on the basis of the State ratio.

Source: Division of Hospital Facilities, Oct. 25, 1948.

TABLE IV.—*Total number of hospital beds needed, existing, and additional needs—Reported in official State plans for hospital construction—As of Oct. 25, 1948* [1]

TUBERCULOSIS BEDS [2]

State	Average annual TB deaths 1940–44 [3]	Total beds needed [4]	Existing beds			Additional beds needed
			Total	Acceptable [5]		
				Number	Per death	
Total United States and Territories [6]	62,339.0	155,502	84,957	72,052	1.16	83,715
Total United States [6]	57,045.8	142,271	81,496	69,243	1.21	73,293
Alabama	1,383.2	3,458	579	519	.38	2,939
Arizona	888.0	2,220	396	396	.45	1,824
Arkansas	932.0	2,330	1,351	1,351	1.45	979
California	3,839.2	9,598	6,784	2,231	.58	7,367
Colorado	399.2	1,704	1,270	1,050	2.63	654
Connecticut	597.0	1,492	1,721	1,721	2.88	
Delaware	126.0	315	193	193	1.53	122
District of Columbia	596.4	1,491	1,177	1,052	1.76	439
Florida	872.0	2,180	1,018	515	.59	1,665
Georgia	1,318.8	3,297	1,288	1,288	.98	2,009
Idaho	94.8	237	55	55	.58	182
Illinois	3,083.2	7,708	4,570	4,570	1.48	3,138
Indiana	1,221.0	3,053	1,779	1,136	.93	1,917
Iowa	392.0	980	791	672	1.71	308
Kansas	404.0	1,010	458	458	1.13	552
Kentucky	1,830.0	4,575	1,607	1,564	.85	3,011
Louisiana	1,310.0	3,275	940	909	.69	2,366
Maine	295.0	737	526	526	1.78	211
Maryland	1,271.0	3,177	1,883	1,743	1.37	1,434
Massachusetts	1,763.2	4,408	3,673	3,604	2.04	804
Michigan	1,770.4	4,426	4,645	3,811	2.15	615
Minnesota	735.0	[7] 1,838	1,924	1,859	2.53	
Mississippi	973.2	2,433	541	458	.47	1,975
Missouri	1,635.0	4,087	1,805	1,805	1.10	2,282
Montana	199.0	497	235	235	1.18	262
Nebraska	201.0	503	200	200	1.00	303
New Hampshire	124.0	310	189	189	1.52	121
New Jersey	1,856.0	3,590	3,359	3,359	1.81	231
New Mexico	374.8	937	284	284	.76	653
New York	6,092.0	15,230	11,594	11,594	1.90	3,636
North Carolina	1,396.0	3,490	2,014	1,830	1.31	1,660
North Dakota	104.0	[7] 260	275	275	2.64	
Ohio	2,841.0	7,103	3,298	2,785	.98	4,318
Oklahoma	996.4	2,491	1,186	1,186	1.19	1,305
Oregon	292.6	732	576	492	1.68	240
Pennsylvania	4,136.0	10,340	5,647	3,609	.87	6,731
Rhode Island	285.0	713	629	629	2.21	84
South Carolina	782.0	1,955	903	903	1.15	1,052
South Dakota	181.2	453	192	192	1.06	261
Tennessee	2,096.8	5,242	1,142	1,142	.54	4,100
Texas	3,480.0	8,700	2,124	2,103	.60	6,597
Utah	66.0	165	96	96	1.45	69
Vermont	120.0	300	147	147	1.23	153
Virginia	1,494.8	3,737	1,511	920	.62	2,817
Washington	586.4	1,466	1,317	833	1.42	633
West Virginia	806.4	2,016	1,321	1,021	1.27	995
Wisconsin	760.8	1,902	2,201	1,651	2.17	251
Wyoming	44.0	110	82	82	1.86	28
Total Territories	5,293.2	13,231	3,461	2,809	.53	10,422
Alaska	373.0	932	137	116	.31	816
Hawaii	265.0	661	1,048	439	1.66	222
Puerto Rico	4,637.2	11,593	2,254	2,254	.49	9,339
Virgin Islands	18.0	45	22			45

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Contruction Act (Public Law 725, 79th Cong., Aug. 13, 1946), as amended (Public Law 723, June 19, 1948, and (Public Law 830, June 29, 1948, 80th Cong.), excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals for the diagnosis and treatment of tuberculosis, excluding preventoria.

[3] Average annual deaths from tuberculosis over the 5-year period from 1940 to 1944 inclusive as reported in the State plans.

[4] Total beds needed as calculated on the basis of a ratio of 2.5 beds per average annual death from tuberculosis.

[5] Number of existing beds which are reported as "acceptable"; excludes beds classified as "nonacceptable" by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[6] Excludes Nevada, which has not submitted a plan.

[7] Total beds needed does not equal the sum of existing acceptable plus additional needed in Connecticut, Minnesota, and North Dakota, where existing beds exceed the number allowable on the basis of the State ratio.

Source: Division of Hospital Facilities, Oct. 25, 1948.

TABLE V.—*Total number of hospital beds needed, existing, and additional needs—Reported in official State plans for hospital construction as of Oct. 25, 1948* [1]

CHRONIC BEDS [2]

State	Total beds needed [3]	Existing beds			Additional beds needed
		Total	Acceptable [4]		
			Number	Per 1,000 population	
Total, United States and Territories [5]	[6] 276,782	36,161	28,492	0.20	248,319
Total, United States [5]	[6] 271,428	35,943	28,388	.21	243,069
Alabama	5,456	----------	----------	----------	5,456
Arizona	1,298	19	19	.03	1,279
Arkansas	3,755	----------	----------	----------	3,755
California	16,678	5,282	3,434	.36	13,244
Colorado	2,120	31	31	.03	2,089
Connecticut	4,032	465	465	----------	3,567
Delaware	586	236	236	.81	350
District of Columbia	1,630	315	170	.21	1,460
Florida	4,497	493	450	.20	4,047
Georgia	6,176	1,085	1,085	.35	5,091
Idaho	945	163	163	.35	782
Illinois	15,096	388	388	.05	14,708
Indiana	6,775	79	79	.02	6,696
Iowa	5,078	----------	----------	----------	5,078
Kansas	3,586	----------	----------	----------	3,586
Kentucky	5,041	223	----------	----------	5,041
Louisiana	4,937	----------	----------	----------	4,937
Maine	1,748	170	170	.19	1,578
Maryland	4,036	2,521	1,713	.86	2,323
Massachusetts	9,136	1,100	1,100	.24	8,036
Michigan	12,100	992	872	.14	11,228
Minnesota	5,636	398	209	.07	5,427
Mississippi	3,980	137	125	.06	3,855
Missouri	7,552	1,081	1,081	.29	6,471
Montana	954	----------	----------	----------	954
Nebraska	2,551	----------	----------	----------	2,551
New Hampshire	1,026	198	198	.40	828
New Jersey	8,434	2,302	2,302	.55	6,132
New Mexico	1,070	40	40	.07	1,030
New York	27,696	5,165	5,165	.37	22,531
North Carolina	7,145	160	160	.04	6,985
North Dakota	1,039	108	108	.21	931
Ohio	14,998	609	----------	----------	14,998
Oklahoma	4,069	----------	----------	----------	4,069
Oregon	2,905	----------	----------	----------	2,905
Pennsylvania	20,008	1,242	896	.09	19,112
Rhode Island	1,471	1,192	1,192	1.62	279
South Carolina	3,766	60	60	.03	3,706
South Dakota	1,089	----------	----------	----------	1,089
Tennessee	5,665	247	247	.09	5,418
Texas	13,919	1,971	1,869	.27	12,050
Utah	1,184	----------	----------	----------	1,184
Vermont	728	----------	----------	----------	728
Virginia	5,620	----------	----------	----------	5,620
Washington	[6] 3,908	5,619	3,937	2.02	----------
West Virginia	3,434	----------	----------	----------	3,434
Wisconsin	6,325	1,852	424	.13	5,901
Wyoming	550	----------	----------	----------	550
Total, Territories	5,354	218	104	.04	5,250
Alaska	175	44	44	.50	131
Hawaii	1,048	114	----------	----------	1,048
Puerto Rico	4,078	60	60	.03	4,018
Virgin Islands	53	----------	----------	----------	53

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., August 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals, the primary purpose of which is medical treatment of chronic illness, including the degenerative diseases, and which furnishes hospital treatment and care; excludes tuberculosis and mental hospitals, nursing homes, and also institutions, the primary purpose of which is domiciliary care

[3] Total beds needed as calculated on the basis of two beds per thousand population.

[4] Number of existing beds which are reported as "acceptable;" excludes beds classified as "nonacceptable" by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[5] Excludes Nevada, which has not submitted a plan.

[6] Total beds needed does not equal the sum of existing acceptable plus additional needed in Washington where existing beds exceed the number allowable on the basis of the State ratio.

Source: Division of Hospital Facilities, Oct. 25, 1949.

TABLE VI.—*Number of existing and programed health centers and auxiliary facilities—Reported in official State plans for hospital construction as of Oct. 25, 1948* [1]

State	Health centers [2]			Auxiliary facilities		
	Total	Existing	Pro-gramed	Total	Existing	Pro-gramed
Total, United States and Territories	2,321	468	1,853	2,108	722	1,386
Total, United States	2,226	426	1,800	2,066	695	1,371
Alabama	67	35	32	12	2	10
Arizona	9	3	6	16	1	15
Arkansas	77	5	72	----------	----------	----------
California	160	33	127	121	55	66
Colorado	16	2	14	32	----------	32
Connecticut	62	31	31	----------	----------	----------
Delaware	5	----------	5	----------	----------	----------
District of Columbia	6	1	5	----------	----------	----------
Florida	39	3	36	164	16	148
Georgia	57	12	45	128	12	116
Idaho	6	2	4	17	----------	17
Illinois	253	1	252	----------	----------	----------
Indiana	37	1	36	----------	----------	----------
Iowa	27	1	26	----------	----------	----------
Kansas	49	16	33	----------	----------	----------
Kentucky	22	8	14	104	88	16
Louisiana	49	----------	49	52	----------	52
Maine	25	----------	25	----------	----------	----------
Maryland	33	18	15	114	113	1
Massachusetts	41	11	30	2	1	1
Michigan	79	45	34	17	17	----------
Minnesota	11	1	10	2	----------	2
Mississippi	72	19	53	173	14	159
Missouri	41	11	30	----------	----------	----------
Montana	13	1	12	1	----------	1
Nebraska	23	2	21	6	4	2
New Hampshire	----------	----------	----------	----------	----------	----------
New Jersey	42	----------	42	----------	----------	----------
New Mexico	10	9	1	32	13	19
New York	188	30	158	288	288	----------
North Carolina	101	12	89	14	----------	14
North Dakota	8	2	6	----------	----------	----------
Ohio	37	----------	37	58	----------	58
Oklahoma	68	7	61	18	2	16
Oregon	18	12	6	7	3	4
Pennsylvania	46	22	24	----------	----------	----------
Rhode Island	7	7	----------	----------	----------	----------
South Carolina	46	8	38	236	5	231
South Dakota	11	----------	11	----------	----------	----------
Tennessee	94	12	82	111	34	77
Texas	80	14	66	150	9	141
Utah	16	2	14	2	1	1
Vermont	5	----------	5	13	----------	13
Virginia	78	15	63	13	3	10
Washington	20	7	13	54	13	41
West Virginia	22	3	19	60	----------	60
Wisconsin	44	1	43	45	1	44
Wyoming	6	1	5	4	----------	4
Total, Territories	95	42	53	42	27	15
Alaska	15	15	----------	2	2	----------
Hawaii	11	3	8	33	22	11
Puerto Rico	68	24	44	3	3	----------
Virgin Islands	1	----------	1	4	----------	4

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948. 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Number of publicly owned facilities utilized by a local health unit for the provision of public-health services.

[3] Number of publicly owned auxiliary facilities such as laboratories or clinics physically separated from the administrative offices of the local health unit.

Source: Division of Hospital Facilities, Oct. 25, 1948.

Mr. Wilson. Mr. Cruikshank, how many members are there in the A. F. of L.?

Mr. Cruikshank. Just under 8,000,000, now.

Mr. Wilson. Of that number of members, how many of them or what percent of those members have coverage of some type, whether incomplete or comprehensive, or any type?

Mr. Cruikshank. We have tried to ascertain that. There is such a wide variety of plans that any figure that I give you has to have a big question mark after it; but, as nearly as we can figure, there are about 1.25 million.

Mr. Wilson. That is, 1.25 million out of 8 million?

Mr. Cruikshank. Yes.

Mr. Wilson. Who have some sort of coverage?

Mr. Cruikshank. Yes.

Mr. Wilson. Have you experienced similar difficulties in your bargaining with employers, as related by Mr. Kramer, and the preceding witnesses?

Mr. Cruikshank. Yes; we have, and we also have this difficulty: You see, in order to get a health-insurance plan in operation, you need a combination of a number of factors. You need, first, strong bargaining positions; secondly, you need to have either one of two things, either a rather relatively immobile labor group such as those in the needle trades, for example, whose employment is rather continuous with either one employer or a group of employers. Lacking that, you need to be in a large metropolitan center where the shifts between employers are absorbed.

et me illustrate: The needle-trade unions in the International Ladies Garment Workers Union have quite a comprehensive plan of their own, now financed under collective bargaining. They have a health center which has been in operation over 35 years. They themselves recognize their own inadequacies, and the International Lady Garment Workers Union has on numerous occasions endorsed health insurance as the only complete and satisfactory answer for even that group. But they are largely concentrated in the large industrial areas and have rather continuing, steady employment within their industry.

Now, contrast that with the building trades, for example. They have the first factor. They have a favorable bargaining position, but it is a highly mobile group. An electrician will be working for an electrical subcontractor on this day, and another one later in the week, and often for as many as a half dozen employers within a month. Now, unless he is in a large, metropolitan center such as New York, where there is a working plan such as there is in New York, and his union can negotiate with an association of employers who join this plan, such a worker has no plan available to him through the agency of collective bargaining.

In the territory in which I was raised, a small town near Toledo, Ohio, our building-trade men have a favorable collective-bargaining position, but they are in Toledo today and Detroit tomorrow and down in Columbus the next day, working for different employers. So, there has been in the building trades very little successful collective bargaining in the coverage of insurance of that type.

Mr. Wilson. That particular trade would account for at least a part of the reasons why there is such a big difference between the 1.25 million and the 8 million.

Mr. CRUIKSHANK. The industrial type of union can bargain successfully if it is in a favorable position, more because there is a more stable relationship, generally speaking, with one employer or group of employers. The International Lady Garment Workers Union is an industrial union, and it is in a position to do that.

Mr. WILSON. Regarding page 3 of your statement, you speak of the six States that provide no medical-service plans, and that there are 22 States that have legal restrictions against consumer-controlled plans. Do you have the names of those six States?

Mr. CRUIKSHANK. I do not have them now, but I would be glad to furnish them. I know what some of them are. Illinois happens to be one that has no plan except a list of approved insurance carriers.

Mr. WILSON. That brings to mind the question of whether or not a plan that might be devised for an over-all Federal medical plan would encounter difficulties at the State level on legal restrictions by their own statutes.

Mr. CRUIKSHANK. No; the Federal plan would not, because these restrictions would prevent for the time being the development of a part of the plan—that is, the cooperative emphasis that is in part of title 4, I believe, would be restricted in 22 of these States. That would be so unless they could get their State legislatures to act.

But the over-all operation of the insurance plan would not be effected, because that is primarily a plan for the payment of medical care and services and not medical-service plans.

Mr. WILSON. Mr. Chairman, may the witness have permission to provide a list of those 22 States?

Mr. PRIEST. Without objection, that will be done.

(The information was not supplied by the witness.)

Mr. CRUIKSHANK. You will find large industrial States like New York, Massachusetts, and others. Pennsylvania is one.

Mr. WILSON. I have one further question.

Now, I notice on page 4 of your statement, speaking about the increase of young doctors, I think every Member of Congress, as well as the country at large, is concerned with that subject. In the statement here:

> When this program has been in effect for some years, we look forward to there being not only more doctors, but more doctors who understand the problem of the working people, as sons of workingmen would then have a chance to enter the profession.

I think that you have made an excellent witness, but I want to differ with you on that. In my experience, at least, sons of workingmen, like young men of all classes, have an opportunity to enter that profession. That has been my experience, but I also share with you the thought that, for some reason, whatever that reason is, good or bad, it has been held down and the numbers of people that can enter the medical schools, who will be our doctors, have been limited. Do you have any thoughts along that line?

Mr. CRUIKSHANK. That is right, Congressman. There are numerous restrictions that have been put into effect. The month before last, in April, I had the privilege of addressing the third-year class of Harvard Medical School. I asked the dean about the constituency of the class. He said that about half of the class were sons and daughters of well-to-do doctors—about three or four ladies were in the class—about half of the remainder are the sons of well-to-do businessmen.

I said, "How about the other fourth?" He said, "Most of them are here on GI study programs, and there are 3 or 4 young men who were married and who, with their wives working and their own work after hours, are trying to put themselves through. He said there were 3 or 4 in this class of 125, and that they were having an extremely difficult time, and he did not know whether they would make it.

The demands of a medical student are not only financially severe but, as I am sure you all know, they are very severe and exacting in terms of time. There is very little opportunity for outside employment while a person is in medical school.

Mr. WILSON. Did you learn how many applicants there were that year for that class in which there were only 125 graduates?

Mr. CRUIKSHANK. He told me that there were several times the number of applicants that they were able to accept.

Mr. PRIEST. If there are no further questions, we thank you, Mr. Cruikshank.

Mr. O'HARA. I have one more question, and I apologize for delaying you; but, Mr. Cruikshank, what would happen to these volunteer plans in case section 7 was adopted?

I am speaking now of these plans. Not only the Blue Cross and the Blue Shield, but the arrangements which the unions themselves have made, and the employees have made with reference to health care.

Mr. CRUIKSHANK. We would anticipate that a great many of the plans, or some few of the plans, could be incorporated practically as they are. For instance, the HIP plan in New York is one, and they would become agencies under the bill for the rendering of service. The bill, as you know, provides that there is not only a free choice of the physician but the choice of an agency or a group program or a group of doctors or a group of people organized to render medical service and care. That is as distinguished from one providing an indemnity.

Now, many of the plans would have to be revised in order to come up to the standards that are required. We anticipate that there would be a Nation-wide movement among these plans to meet the standards. There is pressure among the membership to have them meet higher standards as it is, but this would give a great incentive, and they would organize on the basis that would enable them to meet the standards so that they could become an operating agency wtihin the bill or within the agency, and we believe that there would be a great movement to expand and improve the voluntary medical service agencies.

Mr. O'HARA. How would you meet the basic problem? You base your estimates of the cost of this program on certain standardized charges for medical and hospital care. Now, let us say the Government took over the guaranties of that. How would we know whether that cost of medical or hospital care would go up or go down?

Mr. CRUIKSHANK. I do not believe that you could attempt to police the charges, the individual charges, at all. You mean made by the doctors and hospitals?

Mr. O'HARA. That is what I am getting at.

Mr. CRUIKSHANK. I think that you would have to rely on a great deal of the profession itself to keep them within reason. The schedules are set. The schedules under the act would be set on recommendation of local physicians. Those would be matters of public information as to how they were set.

I think that they would be responsive to the public pressures that would be on them to keep those charges within reason, because people know what the charges are, generally, except in the case of schedules that are made as side deals between some individuals and physicians; but what the standard charges are is rather generally known, and they would be public knowledge. There would be the usual democratic pressure.

Mr. O'HARA. The reason I asked that question has been the repeated objection to the fact in the Blue Cross or the Blue Shield that the charges made on the side were over and above that which has been the recognized standard or agreed standard of charges to be made for the services rendered.

How are you going to change that in this bill?

Mr. CRUIKSHANK. I do not believe that you can change or should attempt to change abuses of that kind by this kind of a bill. There are a number of abuses in the medical profession which this bill does not touch. But we do not look upon it so much as a reform bill in medical practice. We look upon it as a bill which meets the major problem of facilities, personnel and method of payment, and rely on the profession itself and on public opinion to meet many of these needed reforms in medical practice.

Mr. O'HARA. I have one other question, and I again apologize for keeping you. Do you think that there is ever a danger in a democracy of a government becoming overpaternalistic?

Mr. CRUIKSHANK. Yes; I do. I think if the people look upon their Government as something just outside and beyond and separate from the people and begin to look at this outside agency as the Great White Father which does things for them, that is a very serious danger.

If, however, we can maintain that attitude which I think we have successfuly maintained thus far in our history—that the Government is nothing but the organization of the people themselves and that the instrumentality of the Government is something which the people can employ to do the things together which they cannot do separately and individually—we can preserve freedom within the framework of a government that is organized to meet the people's needs.

Under this bill, for example, we are not looking to the Government to buy all medical practice and make it available freely. We are simply employing the instrumentality of our Government to provide a different and more sound method of meeting the costs of medical care. We are not having something done for us, but we are doing it for ourselves through the instrumentality of a democratic government.

Mr. O'HARA. My point and the concern I have is to the point of the difference between statism and excess of government paternalism in considering some of these very difficult problems, and I am sure, Mr. Cruikshank, you share that same concern.

Mr. CRUIKSHANK. I do.

Mr. PRIEST. We appreciate your statement, sir.

The next witness is Mrs. Joseph Stoll.

May the Chair announce at this time that it will be necessary to adjourn this hearing at 12:15.

In addition to Mrs. Stoll, we also have Mr. Davis from the Department of the Interior and Mr. Smith from the Bureau of Agricultural Economics. We hope to hear all three of these witnesses, and at this point the Chair would like to ask unanimous consent to insert at the close of the hearing today some statements that have been made available through the mails, one from Dr. Grossman, a dentist; another one from the president of the communication workers; another from Dr. Chester D. Swope, chairman of the public relations, American Osteopathic Association; a letter from the Veterans' Administration.

The Chair would also like to ask unanimous consent to insert in the record one or two other letters that have been sent to the chairman's office, requesting that they be inserted, but are not available at this time.

Without objection, these will be inserted in the record at the close of today's hearings.

Mrs. Stoll, you may proceed.

STATEMENT OF MRS. HESTER G. STOLL, CHAIRMAN OF THE SUBCOMMITTEE ON HEALTH OF FEDERAL LEGISLATION COMMITTEE, AMERICAN ASSOCIATION OF SOCIAL WORKERS

Mrs. Stoll. I am the chairman of the subcommittee on health of Federal legislation committee of the American Association of Social Workers, and I appear as a substitute for Mr. Joseph Anderson, our executive secretary, who presented himself several weeks ago and found the schedule had been changed. He had to be out of the main office in New York today, and could not come here, so I appear for him.

I would like to present this testimony for our association.

Mr. Priest. Mr. Anderson's statement was included in the record. That is already in the record.

Mrs. Stoll. I have the statement here, and I wanted to read a little of it and comment upon it, with your permission.

Mr. Priest. This is the statement that is already in the record?

Mrs. Stoll. Yes.

Mr. Priest. All right. I hope, if you can accommodate the committee by summarizing it as much as you can, that you will do that. It will be most helpful.

Mrs. Stoll. The Association of Social Workers is a national association. It was founded 26 years ago and now has 11,500 members living in all parts of the United States and its Territories. These social workers are employed in private and public agencies at the international, National, State, and local levels. We have approximately 100 chapters in every part of this country. We have long felt a responsibility to make our views known to people who have the utlimate responsibility of making the laws, and for this reason we have for years considered what our position is on health and medical care.

Our association was founded 26 years ago, and during the last 10 years we have been concerned with studying health needs and evolving principles upon which we think a national-health and medical-care program should be based.

At our last annual conference held in Atlantic City in April 1948 we adopted a platform on health and medical care, and we use the principles in this platform as our yardstick when we look at any legislation, any Federal legislation.

This association has empowered Mr. Joseph Anderson, our executive secretary, or anyone whom he may delegate, the function of presenting our view, always with the platform as our touchstone. We believe that a national program is essentially a broad part of a program of social service and the physical and mental well-being of every person in the United States, its Territories, and possessions, is the concern of the Government. We believe that a medical-care program must include preventive, diagnostic treatment, convalescent and chronic aspects of care, and it should aim at rehabilitation wherever possible.

Now, I shall not attempt to give our statement in detail, but I would like to reiterate the statement that we believe facilities and services as well as benefits should be provided for all people in the United States as a matter of right, regardless of race, creed, citizenship, resident or economic status.

With this idea in mind, we have examined a number of proposals before the Congress, and particularly H. R. 4312 and 4313. When we consider what a comprehensive program is we believe that it should include this: Public health, medical care, surgical care, psychiatric, dental, and nursing services, including all specialties. In other words, we would approve of what has been said this morning, prior to now, about a comprehensive program. We believe it should be available to everyone in this country.

We find one very good thing about these two bills, 4312 and 4313, and that is they offer opportunities to families in the middle-income brackets to pay for medical expenses while they are well, and according to their income. We social workers know so well the situation of mddle-income families who can meet their needs until a sudden illness comes. I want to read these two cases as illustrations, because I think that they bring out the heart of the problem.

For example, here is a man who earns $3,045 take-home pay a year in a local government position. His wife ears $1,433 as a teacher in a private school. They have one child, a 6-year-old son. The wife was operated on for an intestinal obstruction, and had to be hospitalized three times in a 4-month period. The medical bills were as follows: Hospital care, $306; X-ray and laboratory services, $45; private nursing, $720; medication, $21. This came to $1,092. This family went in debt to pay these bills. The wife had not yet received a bill from her private physician and she is distressed as to how she can pay it when it comes. An additional expense had been the $374 for a substitute at school while she was absent for the 4-month period.

Unfortunately, this family had no protection against these medical costs. If they had had voluntary hospital and health insurance, the annual premium would have been approximately $60 to $80 a year, and would not have covered the largest item in this case, the $720 for nursing. It would not have covered much of the doctor's fees. Under H. R. 4312 and H. R. 4313, this family would have had to pay no more than $72 a year for complete medical costs. We are making this computation here at 1.5 percent of the first $4,800 and this family would probably have had about $4,800, and therefore would have had to pay $72 a year.

This is one reason we find these bills favorable to our position. They cover the medical expenses of that great middle-income group which has a hard time paying its bills.

Then we have learned that many people think the voluntary plan can solve the problem of paying for medical care. Our experience with these plans leads us to believe that they are inadequate to meet the problems. Most voluntary plans restrict their services, often not covering many illnesses or the full cost of needed medical care.

Mr. Priest. I just want, for the sake of the record, to be certain that there is not a duplication in the record. Is that statement in the record; the statement that you are reading?

Mrs. Stoll. I am summarizing a little, but that is it, approximately.

Mr. Priest. It makes the record look bad when we have a statement over on page 124 and then an identical statement at 1630. If you can change the language and summarize, it would not be so bad, and would look better in the record.

Mrs. Stoll. Thank you, sir. I will put my testimony aside and continue speaking on this problem.

Mr. Priest. I think that would be better for the sake of the record.

Mrs. Stoll. The difficulty with the voluntary plans as now set up is that they cover so little of the total medical cost which we social workers know so well from our dealings with the very poor and with the middle-income groups. Some of these plans cover care in the hospital, but do nothing about the care that people need in the doctor's office. Many times a mother will take her child in to see a doctor, and that part she must pay. If the child needs to go to a hospital for surgery, perhaps part of that doctor's charge is covered, but the greater part of the year-round, routine care is not covered by the insurance.

This is the point that is brought to us often, and I wanted to make it again.

Then I wanted to say that we social workers believe that the means test is undermining to morale. When we talk about the means test, we mean the eligibility test. Social workers have had more than 10 years' experience in the public programs offering the services for the aged, the blind, the aid to dependent children. We know how difficult it is to handle the eligibility factors in these programs. In these programs our emphasis is on living costs: rent, food, clothing, things you can predict and things that you can really count up and see how much a person needs during the year to get along. When it comes to medical care, it is so difficult to do that. How can I predict that you might need an appendectomy a week from now? Many people can pay their ordinary medical costs, but here comes a long-time incapacitating illness, and how can average people with average incomes handle this?

Recently a situation came to my mind, and this is not in the record, of a woman, a widow, who has been making a very modest living from sewing for many years. About a week ago she came down with a very serious illness requiring emergency surgery, and was taken to a hospital. She has two sons, each of them with children. One is starting in a new business and could not possibly help her. The other son already has a small business, but does not have a large income from it. Here is a woman who needed medical care, and she did not have time to think about where to go to get certified for charity care. She had to go into the hospital for an operation, and she had to go that night.

Bills immediately started flowing to this woman, and she has no time to think about whether there is a cheaper way in which to do this. How is she going to pay a $500 surgical charge? It is a problem that confronts many people who come down with emergency sickness.

We not only object to the means test, we object to any legislative proposals that limit services to those given in hospitals and outpatient departments. H. R. 4312 and 4313 not only cover hospitalized illness, but provide services to patients in their own homes, and also in physician's offices. In the long run, we feel this saves money, and is an economical way to care for people who cannot pay their medical costs under the present system.

I am not going to repeat our statement on finances, but I want to emphasize the fact that we believe that compulsory health insurance is the only way that the average person can pay for his medical costs. That is, for the care that he really needs. Also, we feel that unless we have a source of income, from compulsory taxes it might be difficult to expand these other health services which have been mentioned by former speakers this morning.

We want to go on record as saying that we approve the other titles of 4312 and 4313 in addition to title 7. We are very much interested in the expansion of health facilities, education and training of health personnel. We believe deeply in an enlargement of research programs. We want further health services, including maternal and child-health care and crippled-children's care, and we want an extension of practice into shortages in rural areas. We believe in group practice, and in fact, we approve all of the titles in the bill but, especially from our own experience, we believe that any proposals before the Congress that do not have title 7 or its equivalent will not meet the need.

We therefore go on record as approving H. R. 4312 and 4313. We believe in its purposes, its principles, and its philosophy, and we hope some action will be taken as soon as possible by the Congress to make care available to the people we know need it.

Thank you very much.

Mr. PRIEST. Are there any questions?

Mr. O'HARA. Do you think the widow seamstress would have been covered by this bill?

Mrs. STOLL. She is a self-employed person, and I believe she would be covered, as I understand the bill.

Mr. O'HARA. Without paying anything into it?

Mrs. STOLL. She would have paid in as a self-employed person under the bill.

Mr. O'HARA. But there are a number of segments of society of our country that are not covered by this bill, is that not true?

Mrs. STOLL. I am under the impression that if a person were certified by a local, appropriate agency, whether health or welfare, as needy, that this department would pay the premium for that person, and then the person would be covered.

Mr. O'HARA. Would you favor a bill which covered everybody and that everybody had to contribute something in direct payment for their health insurance?

Mrs. STOLL. Well, our platform on health expresses the belief that medical care should be a right of everyone, so the first part of your question would be answered in the affirmative, and the question of whether everyone should pay in could be answered in this manner: I realize there are some people who cannot pay in anything. They are not self-employed, and they have no jobs. Someone would have to certify and pay in for them. How that would be done, we believe, would be through the provisions as set up. If it could be done in some other way, that would be equally good. We would not object.

Mr. O'Hara. But the self-employed would have to voluntarily pay in and if they did not pay in they would not be entitled to the benefits, is that not true?

Mrs. Stoll. That is right. However, the law says it is compulsory, and I wonder if it would be a compulsory tax on the self-employed.

Mr. O'Hara. I cannot tell you, madam.

Mrs. Stoll. I was under the impression it was, but I could be wrong. I think the problem is that our principle goes further than these two bills. That is, we would like to see everyone covered, and we understand that these bills will provide coverage for approximately 85 to 90 percent of the population.

Mr. Priest. Are there any further questions?

Mr. Wilson. Mr. Chairman, I would like to ask the lady if the legislation were passed, do you envision that it would call for increases of social workers?

Mrs. Stoll. We think that if any of the other proposals passed that carried an eligibility test, there would have to be a tremendous increase, but if this bill would pass, we would not think so.

Mr. Wilson. I do not mean to be disrespectful, but I have been disillusioned. I thought the social workers' existence was justified by reason of the means test.

Mrs. Stoll. We do many more things than administer programs that have means tests.

Mr. Wilson. I realize that, too, but I was just curious to know if this legislation were passed, would it mean an increase of social workers.

Mrs. Stoll. I do not think it would mean any larger numbers, or any large increase. Now, there may be some social workers who would be consultant to people in the planning and policy positions, but machinery is already set up, as I understand it, through present social insurance for the tax collection. In other words, the Government has already been collecting some taxes now, and this would be another extension of that work. So, for that piece of machinery there evidently would not be need for social workers.

Now, if there were no eligibility test, we would not be needed to help on that part. Some medical social workers might be needed to carry on the same kind of work they are now performing in State health departments and in State welfare departments, that is, helping people who need help in taking the best advantage of medical services. It would facilitate service to people.

Let me illustrate: Here is a person who is quite disturbed and, although the doctor has made a recommendation that he should have a period of convalescence, he cannot accept that. After some discussion with him, the doctor calls in a medical social worker and says, "Will you not help this man make plans for the kind of care he needs? He needs 2 months of convalescence. He is worried about his family and children." The social worker then is a person that helps him work out social plans in order that he may take advantage of his doctor's recommendation. I do not think that there would be any great increase in social workers.

Mr. O'Hara. You do not think that this program would cause any decrease in social work?

Mrs. Stoll. I would have to think about that. It might be that we would be employed in some health agencies now which would not want to be a part of the plan, and would perhaps decrease their services and in that case social workers might be decreased, too. But I think that there are getting to be more social workers all of the time, because there are more calls for them.

Now, if you should pass the program and then a year later there should be more social workers in the United States, I hope you will not say that this one thing resulted from the other.

Mr. Priest. We thank you very much, Mrs. Stoll, for your statement.

Our next witness is Mr. James Davis.

STATEMENT OF JAMES P. DAVIS, DIRECTOR OF THE DIVISION OF TERRITORIES AND ISLAND POSSESSIONS, DEPARTMENT OF THE INTERIOR

Mr. Davis. I shall speak for a couple of minutes, Mr. Chairman, and I ask permission of the committee to supply a short statement.

Mr. Priest. The Chair regrets also that the time is somewhat limited. Thank you very much for your cooperation.

Mr. Davis. I have no intention of going into the great major issues that are involved in the legislation. I am here, like old Cato in the Roman Senate, to insist on a single point connected with the legislation and that is that the Territories and possessions should not be forgotten in this or any other grant-in-aid legislation or general benefit legislation that the Congress may enact.

We have in our Territories about 3,000,000 American citizens. They face all of the problems and many more problems than our fellow citizens here in the mainland. They are loyal and devoted partners in our American Democratic way of life. They have measured up to all of the tests that we apply to other Americans. We cannot afford either for their sake or in the national interest or in maintaining our position in the world of nations to have different classes of citizens.

Federal services, as distinguished from local or municipal or State services, certainly should be fairly and equally available to all of our citizens, wherever they may be. I think that there can be no dispute about the basic logic and soundness of that position.

In the past, it has been too much of the custom to legislate for the Territories through special provisions in general legislation. In many cases, a grant-in-aid program has not been made fully applicable or they have restricted applicability through special formulas such as 2 percent of the total amount made available, or in other ways, or they have set up conditions or formulas that could not be made applicable to the Territories.

I am merely calling the attention of the committee to this situation, and I am urging that in considering the final form in which this legislation will be presented to the Congress, there should be adequate and equal and fair participation by the Territories and possessions.

I have in mind most particularly Puerto Rico, because of its great social and human needs. With 2,200,000 population in 3,500 square miles, a density of over 600 per square mile, without great natural resources, with a government struggling against lack of revenues and making a magnificant effort to rise above the difficulties that confront it, now spending about $13,000,000 a year in public-health programs which is some 20 percent of the total budgetary expenses of the island. It urgently needs assistance. I can assure the committee that all of the help that can be given in dealing with medical and social problems there, in the Virgin Islands and Alaska and Hawaii, is urgently needed, and that every dollar of Federal funds which can be expended there will serve a most worthy and useful purpose.

I think with that general statement, Mr. Chairman, and your permission to file a short statement which points out the specific amendments that would be needed in our judgment to make the bill fully applicable in the Territories and possessions, I yield to the next witness.

(The statement is as follows:)

I appreciate this opportunity to appear before this committee to express my views on H. R. 4312 and H. R. 4313, identical bills establishing a national health program.

The proposed legislation would put into operation a comprehensive national program to improve the health of the people of this Nation by bringing adequate health services within the reach of all our people. I fully support the objectives of this legislation.

In my opinion, however, the bills will fail to fully realize their objectives to the extent that the Territories and possessions of the United States are excluded from some of the essential programs outlined in these bills.

Specifically, the bills fail to include Alaska, Hawaii, Puerto Rico, and the Virgin Islands in that portion of title I, part A, which provides for Federal aid to medical, dental, dental hygiene, nursing and related public health schools, and exclude Puerto Rico and the Virgin Islands from the benefits of title IV which would provide special aid to rural and other areas where medical personnel are in short supply and title VII which sets a system of prepaid personal health insurance benefits.

Section 372 (e) of title I, part A, of the bills would limit Federal assistance to medical and other public health schools in the continental United States, thus making schools in Alaska, Hawaii, Puerto Rico, and the Virgin Islands ineligible for such assistance. I know of no reason why this aid should be limited to schools in the continental United States. (The shortage of physicians, dentists, dental hygienists, nurses, sanitary engineers, and other health personnel which this legislation is designed to eliminate is even more pronounced in the Territories and possessions than in the continental United States; particularly is this so in Puerto Rico, where for a population of approximately 2,250,000 there are only 728 licensed physicians and approximately 1,438 licensed graduate nurses. According to Public Health Service standards at least 2,000 physicians and about 4,000 nurses are required to meet the minimum health needs of the people of Puerto Rico.)

In order to combat this shortage the government of Puerto Rico is planning in the very near future to establish a school of medicine in Puerto Rico. The medical school is an integral and indispensible part of the insular government's effort to cope with the health problems of the community. The extent of that effort is illustrated by the fact that out of a total budget of approximately $62,000,000 appropriated by the insular legislature for 1950, approximately 25 percent, of $15,000,000, is set aside for health purposes. Moreover, the insular government is now spending over $225,000 in medical scholarships alone. I believe that Puerto Rico deserves and should receive Federal assistance for the construction and equipping of this school, and for the meeting of part of the cost in instructing medical students, in the same manner and under the same formula as such assistance would be furnished to schools in the continental United States. The same principle, of course, should apply to Alaska, Hawaii, and the Virgin Islands. To accomplish this objective, I recommend that these bills be amended as follows: on page 16, line 9, delete the words "the continental United States" and substitute in lieu there the words "a State."

The other matter which I should like to raise at this time is the omission of Puerto Rico and the Virgin Islands from the provisions of titles IV and VII of these bills. There is no substantial reason why a program of prepaid personal health insurance and special aid to rural areas should not be made applicable to Puerto Rico and the Virgin Islands. I recommend that the bills be amended by inserting on page 160, line 22, before the word "and" the words "Purto Rico, the Virgin Islands." Since participation under title IV is dependent on participation under title VII, no specific amendment to that title is required for Puerto Rico and the Virgin Islands to be included under its provisions.

The people of Alaska, Hawaii, Puerto Rico, and the Virgin Islands are citizens of the United States; as such their health and welfare are as important to the strength and well being of our Nation as that of the citizens of the 48 States.

I want at this time to urge the adoption of the amendments which I have proposed. I believe that their adoption would not only be in accord with the basic objectives of this legislation, but would, as well, contribute to the maximum effectiveness of the national health program.

Mr. O'Hara. I would like to ask one question: Would you state for the record what the Territorial possessions of the United States are?

Mr. Davis. At the present time they include Alaska, and Hawaii, which are so-called organized Territories, candidates for statehood. Legislation has already been presented by the House Public Lands Committee, and is awaiting a rule in the Rules Committee at the present moment on both the statehood bills for those Territories. Of course, if they become States, they would presumably participate fully in all legislation just as any other State would.

The other Territories are Puerto Rico and the Virgin Islands, which are so-called unorganized Territories, sometimes called possessions. The language is not very definite under which they are classified.

We also have Guam and American Samoa in the Pacific, which are at the present time under the jurisdiction of the Department of the Navy, but which the President has indicated will be transferred within the next year or two to the Department of the Interior for civilian administration, and we have the trust territories of the Pacific, the former Japanese mandated islands.

Mr. O'Hara. How many of those?

Mr. Davis. A very large number, Mr. O'Hara, scattered over 2.5 million square miles of ocean in the Pacific, some 3,000 altogether. But the population is concentrated in relatively few, a dozen or so of the larger islands.

Mr. O'Hara. I think we should have in the record what you considered were the insular possessions of the United States.

Mr. Davis. I am very glad to give that, or any other information which the committee may want.

Mr. Priest. The next witness is Mr. Ray Smith of the Department of Agriculture.

It will be necessary for the chairman to go to the House floor at this time, and Mr. Sadowski will take over and hear your statement, Mr. Smith.

STATEMENT OF RAY SMITH, ASSISTANT CHIEF OF THE BUREAU OF AGRICULTURAL ECONOMICS, DEPARTMENT OF AGRICULTURE

Mr. Smith. Mr. Chairman, I should like to file this statement for the record, and I can devote 1 or 2 minutes and stop, or go over a larger part of it, whichever is your wish.

Mr. SADOWSKI. You may proceed with your entire statement, Mr. Smith.

Mr. SMITH. The Department of Agriculture is keenly interested in rural life and the welfare of farm people. We know that the good health of the farm family, whether it be of an owner-operator, of a tenant or of a hired farm worker, is fundamental to the economic soundness of the farm enterprise, and the welfare of the rural community. We are, therefore, concerned with the health problems confronting farm families and their communities.

Rural health is not just a rural problem. Nearly half of the boys and girls who grow up on farms sooner or later move to the city. Rural communities must have available adequate medical care and other health services not only to maintain good health in rural areas, but also to insure that the young men and women who leave these areas to replenish city populations will have the opportunity while on the farm to obtain adequate health care.

It is generally agreed that before the advent of modern medicine and health care rural people were healthier than city dwellers. A half century ago the urban death rate was 50 percent higher than the rural rate. Today rural people still have a small advantage, but one that has constantly dwindled over the years. Before 1928 the rural infant death rate was lower than the urban. Since 1928 the reverse has been true. The lowest infant death rates are found in the largest cities; the highest in places of 2,500 to 10,000 with rural areas running in between. Taking hospitalization at childbirth as an index of the extent of hospital use, in 1946 less than 70 percent of the rural babies were born in hospitals compared with around 90 percent of those born of urban parents.

Some of the very diseases that modern medicine knows best how to prevent or control now occur most frequently in rural areas. The rural infant's risk of death from dysentery is twice that of the urban child. He faces more than twice the risk of dying from congenital debility, whooping cough, measles, and convulsions. He is more than five and one-half times as likely to die of ill-defined and unknown causes. He is also more likely to have malaria, scarlet fever, chickenpox, and other controllable diseases.

Various measures show a striking disparity between rural and urban places in the health services readily available. Before the war large cities averaged one doctor to 650 people. The third of the counties that are most rural averaged one doctor to 1,700 persons. The war depleted still further the rural supply of physicians, and even since the war a serious disparity remains. The scarcity of dentists and nurses in rural counties is acute. The supply of hospital beds, like the supply of professional personnel, dwindles with increasing isolation.

A recent report in the Journal of the American Medical Association summed up a survey of health services for the rural child by stating that the 13,000,000 children in isolated counties get distinctly less than their share of the service of hospitals, physicians and dentists located in their own areas. The report estimates that the supply of hospital beds in isolated counties needs to be increased by at least 50 percent. If children living in these counties are to have opportunities for medical care equal to those of children in metropolitan areas, the supply of general practitioners would have to be doubled and the supply of dentists tripled. Sixty percent of the children live on farms and in towns of less than 10,000 population. In these areas, where 60 percent of the children live, are located only 4 percent of the pediatricians.

All the available evidence points to the fact that the more rural the county the fewer the doctors, dentists, nurses, hospital beds and other health services in proportion to the population, and in general the lower the expenditures by local governments for public health services. City people have these services practically at their doorsteps. Rural people often must travel long distances to reach them. And distance to be traveled adds to the cost as well as being in itself a barrier to the use of service.

Farm families, like predominantly rural counties and States, have lower incomes than their urban counterparts. During 1941, the latest year for which comparable data are available, farm families spent $14 per person for medical care while city families spent nearly twice that amount per person. But the meager outlay of farm families for medical care represented a higher percentage of their total family income than did the outlay of city families. Farm families spend more for medicines and drugs and less for hospital and dental care than city families. Doubtless this difference can be accounted for in part by the lower incomes of farm families and by the fact that they have less easy access to hospitals, clinics and the services of specialists.

HEALTH ACTIVITIES IN DEPARTMENT OF AGRICULTURE

I should now like to review briefly some of the principal activities related to health conducted by the Department of Agriculture. The Bureau of Agricultural Economics has obtained a limited amount of data concerning the rural health situation as part of its research concerning the levels of living of farm people. Similarly, the Bureau of Human Nutrition and Home Economics, as part of its family expenditure studies, has obtained data on medical care expenditures. The extensive nutrition research carried on by the same bureau has contribute substantially to improved health for all of us. In addition, the Bureau is interested in child development, giving special attention to nutrition for children, along with some consideration of clothing and housing problems.

The Farmers Home Administration, when requested, includes funds in loans to low-income farm families to enable them to join and participate in prepaid and other health services, and gives some aid in improving diets and environmental sanitation. At one time its predecessor, the Farm Security Administration, carried on an extensive health services program. It assisted its borrowers, all low-income farm families, in forming group prepayment medical care plans in more than 1,000 counties. It also assisted, through loans and grants, in developing more comprehensive demonstrational prepaid health-service programs available to all farm families in six experimental counties.

Although the extensive rural health program of the Farm Security Administration no longer exists, many valuable lessons were learned from it. More than a half million farm people gained experience which should be invaluable in planning the local aspects of a national health-insurance program. The county health associations sponsored by the Farm Security Administration represented a definite step forward. Nevertheless, they demonstrated weaknesses that seem to be inherent in any system of voluntary prepayment. These weaknesses include incomplete population coverage, adverse selection of risks, and limited services.

A study of the six experimental county programs was made by the Department's Bureau of Agricultural Economics at the request of the Subcommittee on Wartime Health and Education of the Senate Committee on Education and Labor. The results, which were published by the subcommittee in 1946 as Subcommittee Monograph No. 1, are available to those interested in this experience with prepaid medical care plans in rural areas.

As part of its program of research, service, and education in the field of agricultural cooperation, the Farm Credit Administration has undertaken a study of local cooperative associations organized by farm families and rural townspeople for the special purpose of pooling their resources to provide and maintain health services needed in their communities. The results of this study show that only a few scattered rural groups have succeeded in this type of cooperative effort. This is not surprising since the associations have been handicapped by high costs of building and maintaining hospitals, in many States by the lack of a suitable law under which health cooperatives could be incorporated, and in some areas by lack of cooperation from medical societies.

The Federal Extension Service, in cooperation with the State extension services, through nutrition programs, the personal health improvement programs, of 4–H Clubs, and activities of home demonstration clubs, has contributed to raising the health standards of rural people.

In recent years, in response to a growing demand from rural people, the Federal Extension Service has sought to make a greater contribution to the solution of the complex problems of making modern health and medical services available to all rural people. Since 1946 it has conducted an educational program in coperation with the State extension services to help rural people study their local health and medical needs and develop programs to meet those needs with the aid of all organizations and agencies concerned with rural health improvement.

The special contribution of the Extension Service to this field is the knowledge of and experience in working with farm people. Extension health specialists in about one-third of the States assist rural people to organize for the study of their health needs and direct them to the sources from which they can get technical information and guidance.

In a number of States the extension services have cooperated with health departments in carrying out educational programs in regard to the Hospital Survey and Construction Act and other public-health programs. Similarly they have cooperated with voluntary health agencies. As a result of this educational program, rural people are in better position to obtain doctors and other health personnel, hospitals, public-health units, prepaid medical care, and the benefits of various health programs. At the same time, this educational program has revealed how much more needs to be done to assist rural people to develop needed health and medical services, and how little technical knowledge and guidance are available.

BENEFITS TO RURAL AREAS

The Department is heartily in favor of the objectives of H. R. 4312 and 4313. They would establish a comprehensive national health program for the benefit of both urban and rural people. This program would include education of health personnel, research, improvements in the hospital survey and construction program, special aid for rural and other shortage areas, grants, and prepaid personal health insurance. Certain of the proposals could be of special benefit to rural areas.

Since Federal aid for training professional health personnel will not of itself necessarily benefit rural areas, we are glad to note that special measures to assure necessary attention to rural and other shortage areas are provided. While student scholarships requiring the recipients to practice in rural areas for a certain time may be of some help, scholarships to presently practicing rural physicians also might well be considered. It also should be helpful for professional education to include the opportunity for students to experience the scope and satisfactions of rural practice.

Federal aid for medical schools in rural States; the broadening of the definition of hospital facilities to include diagnostic and group-practice facilities; flexible grants for hospital construction and loans and grants provided in title IV, to assist doctors in getting started in rural practice and to guarantee adequate income, should be of particular value in improving the supply and distribution of health personnel in rural areas.

The passage of the Hospital Survey and Construction Act in 1946 was a symbol of hope to rural people that something concrete would be done to improve their medical facilities. It is inspiring to learn that many rural communities are taking advantage of this law to build long-needed hospitals. At the same time, other communities have been unable to raise their two-thirds share of the funds, or have done so at the price of doing without other needed community services. The flexibility in the Federal Government's share proposed by the bill should be of special benefit to rural areas.

The proposed demonstrations relating to coordinated use of hospital facilities are particularly significant for rural areas. The small rural hospitals being built today will not be able, through their own efforts alone, to bring the best of modern medical science to local communities. Only as they are part of a coordinated hospital system will certain technical skills and specialist services become available to local people. It is to be hoped that the demonstrations will put particular emphasis on serving local people in their own communities by strengthening the services available in their local hospitals rather than by centralizing services in a base hospital. If rural people are to enjoy modern medical services, the major emphasis of such demonstrations must be the support given by the base and district hospitals to associate local hospitals and to rural doctors as they practice and serve the rural population in their communities.

It is encouraging to note in part B of title IV the authorization of Federal grants to farmers' experimental health cooperatives. The Department of Agriculture is particularly interested in farmers' cooperatives, and has tried to further the development of cooperatives among farmers for many years. The experience in the six experimental health cooperatives already referred to indicates that to take full advantage of modern technological advancement in health services any cooperative health association should include all population groups in a given area and should serve all of them, whether or not they live on farms. A practical reason for a broad community or intercommunity approach to the development of health cooperatives is the fact that it takes not only the teamwork of general practitioners, specialists, and technicians to provide comprehensive health services, but also a sizable membership.

The provisions for grants in aid for State and local public health work is of special importance to rural people. It is in rural areas that preventable diseases are most common, and it is in these areas that public health services are least developed. Forty percent of the counties in the United States, most of which are rural counties, still lack full-time local public health services, and where those services do exist, the services are often inadequate. Grants should prove a great stimulus to the blanketing of rural areas with these basic services for health protection.

Perhaps the greatest single contribution to raising rural health standards would be the national contributory sytem of personal-health insurance proposed in the bills. Such a program would increase the medical purchasing power of rural families and communities and thus in time would reduce the disparity between rural and urban people in health services and facilities.

The health of the whole population—that is, of all of us—is a very important matter. Poor health knows no boundaries between farm and nonfarm areas. A basic requirement to safeguarding the health of the Nation is to safeguard the health of rural people adequately. Any program to improve the situation should include development of more and better trained health personnel, research, provision of adequate hospital and other health facilities, expansion of public-health activities and preventive medicine, easing the payments for services by a prepayment plan based on the insurance principle, administration insofar as practicable on a decentralized local basis, and drawing upon the resources of the entire Nation so that rural and other shortage areas would receive benefits along with the rest of the population. H. R. 4312 and H. R. 4313 seem to contemplate such a comprehensive health program. With whatever refinements or improvements that can be made, the Department, believing the need to be urgent, recommends early passage of the proposed legislation.

The Bureau of the Budget has advised that the objectives of the proposed legislation are in accord with the President's program as outlined in his message to the Congress on April 22, 1949.

Mr. Sadowski. Thank you, Mr. Smith. Are there any questions?

Mr. O'Hara. Mr. Smith, can you tell me what the average farm income was for the State of Iowa for the years 1947–48?

Mr. Smith. Mr. Congressman, I cannot give you the figure for Iowa. I would be glad to furnish it for the record, however.

The average per capita net farm income was between $700 and $800 for the Nation as a whole.

Mr. O'Hara. For what year?

Mr. Smith. For the last year on which we have records; for 1948.

Mr. O'Hara. Recently I saw some figures on the average farm income for the State of Iowa, and when you say net income, I do not know what all of that means, but I saw some figures on the farm income for the State of Iowa and it was something like $11,000 to $14,000, if my memory serves me correctly.

Now, I know it was in excess of $10,000 as an average for the State of Iowa. I do not happen to come from that State, except that I was born there and reared there, but I am from Minnesota, as you know, Mr. Smith.

I think that that is probably during the high years. It was either 1947 or 1948.

I would say that that would be relatively the same as the southern half of Minnesota, approximately. Now, what the other States are, I do not know, and you get down into tobacco road and some of those places, it falls off pretty fast; I realize that. But certainly some areas of the country have a very high farm income; is that not true?

Mr. SMITH. My home happens to be in the northwestern part of Illinois, which is close to the southern Minnesota line and the State of Iowa, and I would say, Mr. O'Hara, that I believe you and I and the people in Iowa are very fortunate in living in an unusually high farm income area of the country.

Mr. O'HARA. There is no question about that.

Mr. SMITH. It is far above the average.

Mr. O'HARA. I have one other practical question: How in the world are you going to send a boy to medical school and take him off the farm, finance his medical school and then tell him he is going to have to go back and practice medicine in a rural community?

Mr. SMITH. I tried to make the point that even though he was told as a condition of receiving assistance in education, that he would have to practice in rural areas for a time, that would not solve the whole problem in itself.

Mr. O'HARA. You are not going to be able to legislate on that, are you?

Mr. SMITH. No, sir.

Mr. O'HARA. That has been one of the problems of the country; to get good young doctors to go out and practice in the country.

Mr. SMITH. And I think that they are human, like the rest of us, and interested in advancing themselves economically, and traditionally rural practice has been a poor way for them to do that, and they are smart enough to know it.

It is our hope that under the proposed legislation there would be some equalization of the opportunities for adequate medical care, which is pretty inadequate in many rural parts of this country. If there was that equalization and an increase in the purchasing power of farm people for medical care and other health services, that would tend to improve the rural areas as places in which a doctor could get ahead, economically. I think that in the long run that would be more likely to be effective in getting adequate numbers of doctors in rural areas than would requirement of some condition on a scholarship.

Mr. O'HARA. Mr. Smith, I think it is pretty hard to dictate where a man goes after he has taken a professional course, and amazingly to me, I have lived in a small town of less than a few thousand population, and I know pretty well some doctors in those small towns that are making, conservatively, from $25,000 to $50,000 a year in their practice. I know of some doctors in the city who are having a hard time getting along, and that applies to dentists, lawyers, and everyone else. But they still, some of them, prefer to just get along in the city rather than out in the country. It is sometimes a rather arduous practice in the country. I do not know how we are going to legislate as to compulsion of location; that bothers me; it is a very practical proposition that we have here, and we are confronted with in this whole picture.

Mr. SMITH. Mr. Congressman, the situation at the moment without legislation is obviously very bad, from the standpoint of health personnel of various types, and that applies to doctors and others, to practice in rural areas. The bills proposed—I say the bills, because there are a number of bills on this subject, and I am covering it in a general way—should tend to equalize opportunity of rural people to some extent. It may not give them a complete parity in health service with urban areas, but it certainly should bring about some improvement, particularly since the bill recognizes the problem and through its title IV indicates that some special measures will have to be taken.

Those special measures might not do the whole job, but it does seem to me that they would go some distance in the right direction, and bring about some improvement, at least, over what we have now.

Mr. O'HARA. I have one other question: Would the farmer be covered, other than as a voluntary contributor, to the program under these bills?

Mr. SMITH. As I understand it, as self-employed, most farmers, actual farm operators, would be considered as self-employed, and would participate through paying a tax on their income.

Other farm people, the hired farm workers living on farms, presumably would be covered in the same way that other employed persons are covered.

Mr. O'HARA. Mr. Dolliver, my colleague from Iowa, has just furnished me with the figures of the per capita income of Iowa farmers in 1945, and it was $4,322, and I do not know how many that means on a farm, but recently I saw some figures for 1947 and 1948, and I think it was per farm, of approximately $14,000, as I recall.

Mr. SADOWSKI. That was gross income?

Mr. O'HARA. Yes.

Mr. SMITH. The figures for Iowa would be many times the national average.

Mr. SADOWSKI. Do you find that there is a shortage of doctors in these higher-income rural areas that have been referred to?

Mr. SMITH. Not so much as in the lower-income rural areas. However, if I can recall, as late as, I believe, 1947, I noticed some reports by state medical societies, calling attention to the great need for additional doctors in certain counties in Kansas, for example, and in some other States that are not among the low-income States. I am speaking in terms of farm income. The situation is worse in the poorer areas where farm incomes are lower, but I am inclined to think that there is some shortage also in some of the better areas.

Mr. WILSON. Just let me ask one further question:

Mr. Smith, I noticed on pages 5 and again on page 8 a reference to local cooperative associations organized by farm families and rural townspeople, and again, the statement—

> The Department of Agriculture is particularly interested in farmers' cooperatives, and has tried to further the development of cooperatives among the farmers for many years.

In that first reference, I see that the Farm Credit Administration had undertaken a study, and you had endeavored to very briefly reflect some of the results of that study, that might be handicapped by the high cost of building and maintaining hospitals and sometimes the local laws have prohibitions against cooperatives. Then you refer to part B of title IV the authorization of proposed legislation as it relates to assistance on farmers' experimental cooperatives.

Do you have accessible—and this is the question—does your division of the Department of Agriculture or any division of the Department of Agriculture have accessible that study that was undertaken by the Farm Credit Administration, so that we may have it available to the committee as relating to this particular title of the bill?

Mr. SMITH. The study is still in process, and is not completed. I would say that as soon as it is completed and a report is issued, I am sure it can be made available to the committee. Through a conversation with one of the people working on the report, I tried to get some information on what the study was showing.

Mr. WILSON. Do you have any tentative, up-to-date reports on that particular study? If you have them, I would like to have them in the record.

Mr. SMITH. Mr. Congressman, I will be very glad to ascertain from the Farm Credit Administration as to whether or not they could give us, if not the whole report, at least any parts that could be made available at this time even though their analysts have not yet completed the study. I will be glad to request them to make available anything that can be released at this time.

Mr. WILSON. I ask permission of the chairman that unanimous consent be given that these reports or analyses as may be made available by the Department of Agriculture be included in the record.

Mr. SADOWSKI. Without objection, that will be done.

(The information is as follows:)

STATEMENT CONCERNING RURAL COOPERATIVE HEALTH ASSOCIATIONS PREPARED BY THE FARM CREDIT ADMINISTRATION, UNITED STATES DEPARTMENT OF AGRICULTURE[1]

Many years ago farmers started organizing cooperatives to market their products, purchase supplies, and secure insurance, irrigation, and other services. Farm families and rural townspeople in a few areas are now joining together in a new kind of cooperative to help solve their common health problems.

Available records show that up to the present time about 100 rural health cooperatives have been formed, the great majority since 1945.[2] (See tables 1 and 2.) A few have developed in areas where no doctors or hospitals were locally available. Many of the others developed where the doctors and hospital beds locally available were too few to serve local needs. Usually the organizing groups have had two objectives:

1. To improve and expand local medical and hospital services according to local need;
2. To provide a prepayment system whereby members might budget the costs of service on a group basis.

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[1] This statement is based on information concerning rural health cooperatives assembled in the course of a study now under way.

[2] The associations sponsored by the Farm Security Administration in six experimental counties are not included in this number. For a report of these associations see The Experimental Health Program of the U. S. Department of Agriculture, U. S. Senate, 79th Cong., 2d sess., Subcommittee Monograph No. 1, Washington, U. S. Government Printing Office, 1946.

TABLE 1.—*Rural cooperative health associations for which data have been obtained, number and current status, by States, June 1949*

State	Associations of record	Current status of associations: Operating with prepayment	Operating without prepayment	Building hospital	Collecting funds	Inactive or discontinued [1]	Unknown [2]
	Number	*Number*	*Number*	*Number*	*Number*	*Number*	*Number*
Arizona	1						1
Colorado	2				2		
Idaho	3				2	1	
Illinois	1			1			
Indiana	1					1	
Iowa	1				1		
Kansas	2	1			1		
Michigan	1					1	
Minnesota	7		1	2	1		3
Missouri	1				1		
Nebraska	4			1		2	1
New Mexico	2						2
North Dakota	3				2	1	
Oklahoma	4	3					1
Oregon	4	1			1		2
South Dakota	2	1				1	
Tennessee	1	1					
Texas	51	12	7	4	2	18	8
Washington	5				1	2	2
Wisconsin	4	1			1	2	
Total	100	20	8	8	15	29	20

[1] In several cases an effort is being made to secure a county bond issue for building hospital instead of continuing the cooperative project One association built a hospital and sold it to a doctor.

[2] Available information indicates that all of this group can be classified as rural cooperative health associations. It is possible, however, that more complete data would reveal that some actually do not belong in this classification.

TABLE 2.—*Period of organization or incorporation of rural cooperative health associations for which data have been obtained*

Period of organization or incorporation	Associations of record	Current status of associations: Active [1]	Inactive or discontinued	Unknown
	Number	*Number*	*Number*	*Number*
1925–29	1	1	0	0
1930–34	0	0	0	0
1935–39	2	0	2	0
1940–44	7	4	3	0
1945–49	68	37	19	12
Unknown	22	9	5	8
Total	100	51	29	20

[1] Included in the group of active associations are all those operating facilities whether or not they offer prepaid services, those now building health service centers, and those still collecting funds.

The 100 associations of record have met varying success in their efforts to achieve thier objectives. Of the 100 associations: 20 thus far have succeeded in providing or arranging for health service centers through which they offer prepaid services to their members; 23 are now building or raising funds to build health service centers; 8 own buildings but have no prepayment plan; 29 are now inactive or have discontinued; 20 are believed to have organized as cooperatives but no information about their current status is available.

Typically the development of rural cooperative health associations has centered around small communities. Table 3 groups the associations according to the population of their headquarters community in 1940. Only 18 of the 100 associations of record have been formed in communities of 2,500 or more. Forty-three were organized in communities of less than 1,000.

ASSOCIATIONS NOW OPERATING HEALTH SERVICE CENTERS WITH PREPAYMENT PLANS

The 20 rural cooperative associations now operating health service centers and providing prepaid services indicate the possibilities of this type of organization as one way to help relieve the health problems of rural communities. The following discussion gives some specific facts about these 20 associations and the areas where they operate.

Characteristics of areas

The 20 associations are scattered in 7 States: Kansas, Oklahoma, Oregon, South Dakota, Tennessee, Texas, and Wisconsin. Rural nonfarm and farm families represent about 60 percent of the total population of the counties where the co-ops have headquarters.

TABLE 3.—*Size of communities in which rural cooperative health associations have been organized*

Population of headquarters community, 1940	Associations of record	Current status of associations		
		Active[1]	Inactive or discontinued	Unknown
	Number	*Number*	*Number*	*Number*
Less than 500	13	4	7	2
500–999	30	16	6	8
1,000–1,499	21	13	5	3
1,500–1,999	9	5	1	3
2,000–2,499	9	5	4	0
2,500–4,999	10	4	4	2
5,000–9,999	4	2	2	0
10,000 and over	4	2	0	2
Total	100	51	29	20

[1] See footnote for table 2.

Of the 20 associations: 15 have headquarters in counties with a population of less than 30 persons per square mile; 7 of these operate in counties with less than 10 persons per square mile; 19 operate in counties with more than 3,000 people; only 1 operates in a county with less than 3,000; 7 have headquarters in counties with a population of less than 10,000 persons and an additional 7 in counties with a population exceeding 10,000 but less than 20,000; 14 operate in counties where the rural level of living is above average and 6 in counties with a rural level of living only a little below average; only 2 operate in poor counties[3]; 6 operate in counties with no hospital except the one operated by the co-op; several counties had no doctor before the association brought one in.

Membership

In general the associations place almost no restrictions on eligibility for membership. Any family head or individual may apply for membership, regardless of age or place of residence. Usually membership applications are subject to approval by the board of directors. In addition some associations require a signed statement by an applicant concerning his own health and that of his dependents. Two report that they require a physical examination of all persons before admission for prepaid health services. Existing serious ailments, particularly those requiring surgery, are not covered by the prepayment plans of associations requiring evidence of the health status of applicants before admission to membership. Such restrictions are not barriers to membership, however. Persons with restrictions may join the association but they must pay fees for service for restricted conditions. Other conditions will be covered by the prepayment plan.

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[3] A rural level of living index worked out by the Department of Agriculture combines in a single measure four factors indicating the level of living of farm operator families in a county. These factors include (1) the percentage of farms with electricity in the farm dwelling; (2) the percentage of farms with telephone in the farm dwelling; (3) the percentage of farms with automobiles; and (4) the average value of products sold or traded in the preceding year. This index was used as an indication of rural level of living in the counties where health co-ops operate.

A member must agree to abide by the association's articles and bylaws and other rules and regulations. He must also pay an initial fee before his membership becomes effective. This fee is the investment in an association's facilities and equipment required of all families wishing to become members. The amount of the initial fee charged by different associations ranges from $50 to $100 with the higher figure customary at the present time. The family membership fee is paid only once and entitles all members of a family unit—father, mother, and unmarried children living at home regardless of age—to participate in the association's prepayment plan.

As in other types of cooperatives, the members of a rural health co-op retain control of the association's business operations through a democratically elected board of directors. The board, in turn, employs a manager who is directly responsible to the board for management of the association's business affairs. Professional affairs, on the other hand, are wholly the responsibility of the doctor or doctors with whom the board makes arrangements for service to be provided in the association's health service center.

Recent membership figures have been obtained from 13 of the 20 associations offering prepaid services. These 13 associations, taken altogether, report approximately 8,800 dues-paying member families living on farms and in towns within the areas served. Through these 8,800 family memberships, 31,000 persons—heads of households and their dependents—are eligible for the prepaid services offered by the 13 co-ops.

The total number of dues-paying member families belonging to the 13 associations ranges from less than 300 in the one with the smallest membership to nearly 2,000 in the largest. The following tabulation groups the 13 associations according to number of member families:

Number of dues-paying member families:	*Number of associations*
Less than 300	1
300–399	3
400–499	2
500–599	2
600–699	1
700–799	2
800–899	0
900–999	0
1,000 or more	2
Total	13

Many co-ops draw members not only from the county in which their health service center is located but also from one or more adjoining counties. Taking their membership in relation to the total population of their headquarters county as a rough approximation of the extent to which the total population of their area is covered, it is found that only one association has a membership amounting to more than half of the population of its headquarters county. On the average, the membership equals about 15 percent of the population of the immediate county area.

Typically a co-op's membership is concentrated within a rather limited area surrounding the community where it operates its health service center. Information concerning concentration of membership is available for 12 prepaid service associations. A circle with a radius of 35 miles drawn around each of the 12 cooperative health centers would take in practically all member families. A circle with radius of 25 miles would take in nearly 100 percent of the members of four associations and from about 75 to 99 percent of the members of the remaining eight associations.

The experience of the associations seems to indicate that the fewer the health services that are available within an area, the greater is the local support of the health co-op and this in turn results in greater concentration of its membership. Seven associations operating in counties previously without hospital beds or with less than 25 beds report that practically 100 percent of their members come from within 25 miles. Three associations in counties with more than 25 hospital beds, on the other hand, report that only about three-fourths of their members come from within 25 miles. Associations in counties with a rather acute shortage of doctors likewise report a somewhat greater concentration of members within 25 miles of their health service center.

Cooperative health service centers

Fifteen of the twenty associations providing prepaid services operate health service centers in which doctors' offices and hospital facilities are combined under one roof. Twelve of these fifteen associations own their own buildings; one is using temporary quarters but plans to build soon; one has a long-term lease on a hospital built and owned by the county; and one other uses a building owned by the community but paid for in part by members of the association and in part by a local bond issue and a Federal grant.

Only 2 of the 15 cooperative health service centers have more than 50 beds, 4 have less than 20; 4 have from 20 to 24, 3 have from 25 to 29, 1 has 32, and 1 has 36 beds.

One additional association offering prepaid services operates a hospital but includes no doctors' offices in its building. This hospital has a capacity of 25 beds. Another association operates its own hospital but no information has been obtained as to bed capacity or as to whether or not doctors' offices are included in the same building.

The remaining 3 of the 20 prepaid service co-ops operate health service centers which contain doctors' offices but make no provision for hospital care. Of these three, one has built and owns its own clinic, one operates a clinic in rented quarters, and one uses a community building.

Most of the cooperatives have their own health service centers. Their buildings were financed by the initial fees of $50 to $100 paid by member families and by additional donations of cash, labor, and materials made by member families and other individuals and organizations. Two of the operating organizations obtained Government grants, one from the Public Works Administration and the other under the present hospital construction program. Special drives, local entertainments, linen showers, and auction sales were among other methods used to raise funds. In addition, hospital rooms were usually furnished by local individuals or organizations. Although the cooperatives were not eligible for a discount on surplus property, some of them made large savings by buying war surplus materials and equipment at lower prices than the same items could have been purchased otherwise.

In general, reliable figures for actual costs of buildings and equipment are not available since figures furnished by the associations sometimes represent only the association's actual cash outlay without taking into consideration the value of volunteer labor, donated items, and other money-saving measures. The financing of health facilities and equipment has almost invariably been a difficult and time-consuming process. Most of the associations required at least 2 years to get started. Some required nearly 3 years. Some of the associations now building hospitals or collecting funds were incorporated two or more years ago.

Doctors and other personnel serving in co-op centers

Reports from 12 of the 20 associations providing prepaid service show a total of 35 staff doctors including 29 full-time general practitioners and 1 on a part-time basis, 2 specialists, and 3 dentists, 2 associations have 1 doctor apiece; of these 2, 1 maintains only clinic facilities. The other 10 associations have from 2 to 8 doctors. Eight of the associations operating hospitals average a little less than one employee per bed including nurses, managers, clerical workers, and others.

Usually the agreements made by associations with their doctors are verbal or reported only in the minutes of board meetings. As a rule the associations guarantee their doctors base salaries. Starting salaries range from $7,200 to $9,600 and top salaries from $10,000 to $18,000. In addition fees for home calls usually are collected and kept by the doctors. Several associations have made various arrangements for paying their doctors a bonus out of the association's net income at the end of the year. One association reported discontinuing this practice because it led to dissatisfaction among other hospital and clinic workers. One association provides its chief doctor a house, rent free. Paid vacations and study leave are part of the agreements with their doctors made by several associations.

Sources of financial support for cooperative services

The initial membership fee which is paid only once is used for building and equipping a health service center. Funds to support the day-to-day operations of the co-op centers are obtained from the annual dues paid by members participating in the cooperative prepayment plan, other service fees paid by members, and fees for service paid by nonmembers. A small income from charity cases was reported by some associations but this usually was inadequate compensation for the services performed.

The annual membership dues vary in different associations. These dues must be paid in advance whether or not members anticipate a need for service or make any use of it during a year. The dues range from $12 to $20 for an individual with no dependents; from $18 to $20 for family units of two persons; from $22 to $32.50 for three-person family units; and from $25 to $36 for families of four persons. In addition the associations charge from $2 to $10 for each additional child and from $6 to $12 apiece for other family dependents.

The variations among different associations in annual membership dues result at least in part from the variations in amount and type of prepaid services offered. An association's wholly prepaid benefits usually are limited to services of its doctors in the coop health center. In addition an association usually gives its members limited reduction in charge for hospital care, use of the operating room, X-ray, laboratory, and other special services.

The associations try to keep the amount of the membership dues at a high enough level so that the total dues collected will meet the total costs to the association of the prepaid services used by members. By emphasizing doctors' services in their prepayment plans, the associations encourage their members to have regular physical check-ups and to go to a doctor in time to check an ailment before it becomes serious. Thus the associations hope to assist their members in maintaining good health and in warding off serious illnesses which might require long and costly treatment.

Members of cooperatives assume the major responsibility for making health services available in their communities by their initial investment in facilities and by their regular advance payment of annual dues to help maintain service. They recognize, however, that any health institution must be open to all persons. Accordingly available information indicates that the cooperative health centers are open to members and nonmembers alike. The associations report that from about 10 to 50 percent of the medical and surgical services provided are for nonmembers and from about 15 to 50 percent of the hospital care. Since nonmembers assume no responsibility except to pay for service at the time and according to the amount and type used, they are required to pay the customary fees charged in the area for office calls, hospital care, and other services. The fees paid by nonmembers, as a rule, become part of the general funds of the association.

All charges made by the associations, both to members and nonmembers and including annual dues rates, are subject to change with changes in economic conditions. The necessity for making adjustments in charges so that income will meet costs of operation, of course, is shared by all health institutions and is not limited to coops.

DIFFICULTIES MET IN DEVELOPING RURAL HEALTH COOPERATIVES

Through long experience, rural people have learned a great deal about sound operation of cooperative enterprises. They know about the need for strong organization, well located facilities, capable leadership, and well-informed members. The development of a rural health cooperative presents some of the same problems as the development of any other type of coop. In some areas, for example, local opposition to cooperatives of all types has hindered the development of a health coop. Probably the fact that few of the health associations use the word "cooperative" in their names is traceable, at least in some cases, to an unfavorable local attitude toward all coops.

The problems typical of cooperative enterprises in general, however, are not the only ones met by health coops. The application of cooperative techniques to rural health problems is still new. Rural people have learned that existing cooperative laws usually do not provide for cooperatives to serve their health needs. They have to turn to laws providing for charitable and benevolent corporations or to other laws and in some cases they have had to secure a change in the State law in order to organize a health coop. Some States still have laws specifying that only members of the medical profession and hospital officials may incorporate or stipulating that such persons must have the controlling voice on the board of directors of any medical or hospital service plan.

Even though the State laws may be favorable to the development of a health co-op, rural people have found that arranging for health facilities and services present exceedingly difficult technical problems on which they have often been unable to secure reliable information or assistance. They have sometimes worked almost completely "in the dark" and the fact that they have made mistakes seems less surprising than the fact that they have been able in some cases to build sound organizations.

The 20 associations that have thus far succeeded in carrying out their objectives have encountered many of the same problems that caused other groups to fail. The following discussion includes problems reported by all groups of associations regardless of their current status.

High costs of building and maintaining health facilities

The high costs of building and maintaining health facilities have made the financial problems of rural health co-ops particularly acute. The difficulty of raising the necessary amount, event in rural communities where the family level of living was above average, has caused discouraging delays. Often the groups did not know or greatly underestimated what it would cost to build and equip a health service center. When the goal for building funds was set too low in the beginning, co-op leaders have fund it hard to explain the necessity for raising additional funds later.

Often the associations underestimated, too, what it would cost to maintain a health service center once they had it staffed with doctors, nurses, and other workers. Shortly after they opened their center, several found it necessary to increase dues rates and service charges. This led to misunderstanding and sometimes to distrust when the reasons for the increase were not thoroughly understood by co-op members and by the whole community.

Problems in securing doctors and nurses

Nearly all the organizations emphasize how hard it is to get and keep doctors and nurses in small towns which offer few advantages. The opposition of medical societies added to the difficulty experienced by some associations. This opposition has taken several forms including refusal to co-op doctors of the opportunity of joining the local medical society or of using local hospitals for their patients. Medical opposition sometimes has led to the abandonment of a co-op's prepayment plan.

After a period of operation, several associations lost their doctor and were unable to get another even though they were willing to give up prepayment and simply furnish a doctor a place in which to work on a regular fee-for-service basis. When this occurs, the co-op center stands empty, lacking doctors, nurses, and other workers needed to give it meaning in terms of service to the community.

Problems in obtaining community support

New enterprises frequently are looked upon with skepticism. In some areas the long delays caused by the difficulty of raising funds and other problems added to the growth of skepticism about a health co-op. Some associations felt that they depended on too small a membership group to start. On the other hand, if they had waited until they had a larger membership, the whole project might have failed. Once they got started, some of those who had been skeptical about the idea came in to join.

In spite of the relatively good economic conditions in most of the areas where health co-ops have been formed, the initial membership fee seems a large amount to some families and the associations report that low family income probably keeps some families from joining. Other families fail to join because they are "indifferent," "neglectful," or "prefer to take a chance" rather than investing in health services they "may not need."

Lack of intergroup and intercommunity cooperation

Lack of intergroup and intercommunity cooperation has proved a particularly great handicap to rural health cooperatives because of their need for a good-sized membership in order to provide and maintain even minimum health services. In one area farm families took the initative in planning for a health co-op. Later they found it difficult to get the backing of townspeople although that backing, financially and otherwise, was indispensable to the achievement of the co-op group's objectives. In another area a local farm organization assumed leadership in the beginning. Later it proved difficult to secure the cooperation of other farm families and townspeople.

Sometimes one association has discontinued while another in a rival community went ahead with its plans, usually without the support of the other group. In at least one case, health service centers were built by two associations in neighboring towns only a few miles apart. Thus the area was burdened with the expense of building and equipping two centers where one could have provided better service at less cost.

Most of the associations thus far have a relatively small membership. In some cases even the entire population of the areas they serve probably provides too small a base for the establishment and maintenance of fairly comprehensive health services. There seems to be need for broader planning by cooperative groups—drawing together people and linking together health services available within a larger area—so that reasonably comprehensive service can be offered on some kind of organized basis.

Misunderstanding of prepayment plans

Misunderstanding of their prepayment plans has been another problem to health co-ops. Sometimes members believe that they will be able to obtain services more cheaply by joining the association. They feel disillusioned when they find that the total cost over a period of time remains about the same although the prepayment method eases a family's cost burden during a period of serious or prolonged illness. The fact that the prepayment systems fail to cover the full costs of all services has also proved a disappointment to some members.

Other problems

Among other factors that sometimes have cause discouragement or discontinuance of efforts to carry out a cooperative health project are as follows:

1. Poor choice of location for a health center. (In one State this has sometimes resulted from the legal requirement that co-ops be incorporated only in towns of 2,500 or less.)
2. Failure to secure doctors or managers who understood and sympathized with cooperative principles and methods.
3. Too great reliance on a single leader, particularly when the project was first started.
4. Depending on a paid person to solicit memberships. (While building an organization wholly by voluntary effort often proved extremely difficult, most of the associations felt this method was desirable. One board member said: "If you have to have a paid organizer, you won't have an organization when you finish.")
5. Difficulty of keeping people informed. (Free use of the local newspaper has not been possible in some areas because news about the association was construed as "unethical advertising." Actually, the use of the county newspaper in a rural area is one of the best ways to keep people informed.)
6. Lack of successful experience with other types of co-ops in the area.

FACTORS FAVORING THE DEVELOPMENT ON RURAL HEALTH COOPERATIVES

Although rural health cooperatives have met many problems, they also report that certain characteristics of their areas or of their organizations have favored their development. The favorable factors reported by some associations sometimes counterbalance problems reported by others.

Some associations report that "local need was our greatest asset." They say that there was no hospital in the county, that doctors were needed, and that people were enthusiastic about having care locally available.

Other factors contributing to their success as reported by the associations include the following:

1. Strong community support and loyal membership.
2. Support and cooperation of doctors in the area. (While medical opposition was a major problem in some areas, in others local doctors worked with co-ops. The associations felt that the backing and assistance of doctors helped them avoid mistakes as well as helping to provide an environment in which it was possible for them to carry out their plans.)
3. Good economic conditions at time of organization.
4. Provision of good service at reasonable cost.
5. Effective leadership, hard-working board members, and capable management.
6. Keeping members and whole community informed about what was going on at all times. (The restrictions on use of the county newspaper which prevailed in some areas were not found in others. The support of the co-op project by the county editor proved very valuable to some associations. Circulars, meetings, and other methods were also used to keep people informed.)
7. Example of other successful health co-ops.
8. Strength of other types of co-ops in the area and their history of successful operation.

CONTRIBUTION OF CO-OPS TO SOLUTION OF RURAL HEALTH PROBLEMS

Rural health cooperatives are proof that rural people want doctors and hospitals within a reasonable distance of their homes. They are also proof that rural people are willing to devote a great deal of time, effort, and cash to achieving this goal. In spite of their existing problems and limitations, the co-ops now operating demonstrate that this type of organziation has a contribution to make to the solution of rural health problems. It is more than a contribution of funds for buildings and beds and for payment of health workers. It is an acceptance by local people of local responsibility for meeting local needs. In a very real sense, the co-op groups make better health the people's business.

Mr. Smith. With reference to the six counties that have been studied, the report is already available.

Mr. Wilson. What States were those counties in? Were they selected areas throughout the United States?

Mr. Smith. They were mostly in the South, one or two in Texas, one of them in Georgia, and I believe one in New Mexico, and in one or two other States. Now, that report was published, as I indicated, by a subcommittee of a Senate committee, and it, of course, is available.

Mr. Sadowski. Thank you, Mr. Smith.

At this point in the record, we will include the documents mentioned earlier by the chairman, consisting of papers submitted to the committee by Mr. Cornell Grossman, of Millburn, N. J.; Joseph A. Beirne, president of the Communications Workers of America; Dr. Chester D. Swope, chairman of the department of public relations of the American Osteopathic Association; a letter to Chairman Crosser from Mr. Charles F. Brannan, Secretary of the Department of Agriculture; a letter from Carl R. Gray, Jr., Administrator of the Veterans' Administration; a statement of the Secretary of Labor; and a letter from the Maritime Commission.

We will also insert at this point a statement submitted by Mr. Russ Nixon, Washington representative of the United Electrical, Radio and Machine Workers of America, CIO; a statement by Dr. Charles M. Thompson, National Dental Association; a statement by Mr. H. B. Anderson, Citizens Medical Reference Bureau, Inc.; and statements of the American Public Health Association and the American Pharmaceutical Association.

(The documents are as follows:)

STATEMENT OF CORNELL GROSSMAN, D. D. S., MILLBURN, N. J.

1. The completion of the 4-year high-school course shall be the requirement for admission to any dental or medical college. The high-school course may be commercial vocational, or academic, and shall not mandatorily contain Latin, algebra, geometry, trigonometry, or history of English literature.

2. The dental college course shall be of 4 years, but in the first 2 years shall include sufficient mechanical dentistry to grant to the dental student a certificate at the end of 2 years that he is a "dental laboratory technician."

3. The medical course shall be 6 years and so arranged that the medical student at the end of 1 year shall receive a certificate that he is a "medical laboratory technician." At the end of 2 years he shall receive a certificate that he is a "medical nurse." At the end of 3 years he shall receive a certificate that he is an "X-ray technician." At the end of 4 years he shall receive a certificate that he is a "graduate pharmacist." At the end of 6 years he shall receive his degree as a "doctor of medicine and surgery." And eligible for his national examination and license in medicine after completion of 1 year of internship. He shall be eligible at the end of his 6 years' course for his license examination. His minimmu salary during his internship shall be $200 per month, or $125 per month and maintenance.

I would urge that the internship year be included in the 6-year medical course. Thus the average medical doctor would be at least 24 years old, at graduation and would have been studying medicine itself and in practice in medical college infirmaries from the age of 18 to 24.

4. That any profit or income earned by a dental or medical school shall not be taken from that school by any university or anyone. (The largest dental college had its $750,000 15-year profit taken from it and is in disgraceful condition.)

5. The program to expand facilities for dental and medical education is praiseworthy.

6. National banks shall be permitted to make loans for medical and dental care to needy people so that every American citizen can have the full dental and medical care needed. Said payment of said loan to be guaranteed to the bank by the United States. Said fees and interest and charges shall be conventional and sufficient for a reasonable profit to the bank. Approval of said loan shall be by the bank president, and local health officer shall sign that care is needed, and signature of care needed shall also be by dentist or doctor patient designates. Dentist or doctor shall pay back to the United States Government 10 percent of said Government-guaranteed loan to cover cost of guaranty. Fees charged under said loan shall be not in excess of average prevailing or VA fee. The person receiving this loan shall not necessarily be a pauper, but shall merely be in need of the cash for medical and dental care or hospitalization.

Statement of Joseph A. Bierne, President of the Communications Workers of America (CWA-CIO), Regarding National Health Insurance and Public Health Legislation Embodied in H. R. 4312 and 4313

The Communications Workers of America, hereinafter referred to as CWA, is the dominant labor union in the field of telephonic communications representing 230.000 telephone workers. CWA is affiliated with the Congress of Industrial Organizations.

The membership of CWA extends throughout the entire country and includes a wide variety of persons in jobs covering all phases of the telephone industry. Its activities are not restricted to the largest companies which comprise the industrial empire known as the American Telephone & Telegraph Co. (or the Bell system), but extends to many of the independent companies, large and small, which share the 10 percent of the national business which is not enjoyed by the Bell system.

The persons who make up our union are telephone operators, in both urban centers and widely scattered rural areas, telephone-line construction and repair men, inside plant craftsmen, commercial and accounting white-collar workers, building maintenance and cafeteria workers, all types of electrical-equipment manufacturing employees and research and engineering workers. Approximately 60 percent of our members are women.

We understand that this committee is presently discussing the merits of a National Health Insurance and Public Health Act. At its second annual convention in June 1948, CWA passed a resolution in favor of national health insurance and public-health legislation. A copy of this resolution is attached as appendix A. By means of this resolution it is the expressed desire of 230,000 telephone workers to lend support to H. R. 4312 introduced by Mr. Dingell, and H. R. 4313 introduced by Mr. Biemiller.

Let us point out several factors upon which we base our support.

THE CONCEPT OF INSURANCE IS GOOD

We believe that the general principle underlying insurance is a shifting of the burden of risk from a single individual to the shoulders of an organization of many individuals capable of supporting that risk. H. R. 4312 and H. R. 4313 provides this insurance. They provide it at a comparatively low cost. The legislation further provides benefits which are worthy and desirable.

According to figures published by the American Medical Association in 1946, 75 percent of all American families need financial assistance to pay for any serious illness.[1] Without the benefit of prepaid health benefits, two alternatives are forced upon these people. They can either throw out their chests and accept the unexpected indebtedness or they can beat at the doors of public and private charitable organizations to carry them over this period of financial distress. We prefer neither! And we think both results are economically unsound.

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[1] Testimony of Philip Murray, president, Congress of Industrial Organizations, before the Senate Education and Labor Committee in support of S. 1606 (May 2, 1946), p. 1.

Opponents of these health bills have claimed that freedom of selection on the part of doctors and patients would be hampered. The bills, however, provide for both freedom of selection on the part of patients and the right to accept or reject a patient is granted to doctors. In fact, by merely declaring he does not want to serve patients under the act, a doctor can remain outside of its scope of operation. So far as patients are concerned, it is our belief that greater and wider fields for selection are open to them under the provisions of these acts. Is there any restriction upon freedom of choice more pronounced than the financial inability of consumers of medical services to pay for such services?

"VOLUNTARY" INSURANCE INADEQUATE

The inadequacies of so-called "voluntary" insurance plans, which AMA would have as substitutes for national health insurance, are so basic that they deserve some mention. Briefly, these inadequacies are:

1. Most plans discourage many would-be subscribers by limitations which exclude patients because of age, type of disease, income limits, or minimum number of persons who must enroll in the group;
2. Because of these limitations, those persons who need protection most, do not have it;
3. Most plans are designed only for serious emergency illness; many provide only hospital care;
4. Consumers of medical care rarely have a say in the administration of these plans.

These shortcomings in "voluntary" plans certainly negate the validity of their substitution for a Federal Health Act.

Again and again the term "compulsory" has been associated with H. R. 4312 and H. R. 4313. We believe that the word "compulsory" should only be used when persons are forced to do something against their expressed will. In 1944 a survey of public opinion conducted for the physicians research committee by the National Opinion Research Center at the University of Denver showed that eight-tenths of the public were dissatisfied with the present methods of paying for medical care and that two-thirds would be willing to pay on an insurance basis for complete medical and hospital care for themselves and their families.[2] Based on these figures, it appears that most people want the type of legislation that H. R. 4312 and H. R. 4313 embody. Moreover, in the last election, voters elected a Democratic President and congressional majority. The Democratic Party platform promised health legislation to the American public. Therefore, we can conclude, that the term "compulsory" cannot, in truth, be applied to the pending administration health legislation.

We do not fear a socialization of medicine. The Government has taken an active part in education and housing without resorting to socialization. Socialization of medicine implies that all doctors would become employees of the Federal Government. As we pointed out previously, doctors under H. R. 4312 and H. R. 4313 need not become part of the program if they have no desire to. If they join the program, they are allowed freedom in acceptance of patients and fees will be paid them in accordance with majority preference in a particular locality. This, then, is not socialized medicine.

PROPOSED LEGISLATION IS NOT NEW

The essence of the plan embodied in the subject legislation is not new; it is not foreign. Three States have already taken steps toward achieving the goal that these acts establish. Rhode Island was the first State to pass a cash sickness benefit law in May 1942. Under this law an insurance program was created providing for an exclusive State fund. Benefits are limited to employees collecting workmen's compensation, and sickness benefits are limited to 90 percent of the worker's average weekly wage. California also has a cash sickness benefit law which includes a State fund similar to the Rhode Island plan, but permits voluntary plans as well. New Jersey has a plan similar to the California law, combined with a merit-rating plan and a waiting period of 1 week before eligibility for sickness benefits is established. In New Jersey is also found the world's largest experiment in municipal public hospitalization and municipal aids for public health, the Jersey City Medical Center, which was established originally in 1934 and has been gradually expanding to meet added requirements.

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[2] Ibid., pp. 4–5.

The Federal Government, in fact, already provides some degree of medical care and hospitalization for nearly one-sixth of the United States population. There are 18,000,000 veterans who are entitled to free medical, clinical, and hospital care where space limitations of the Veterans' Administration's facilities permit. There are another million members of the armed forces who, with their families, are given the same kind of care at Government expense.[3] Under H. R. 4312 and H. R. 4313, the rest of the citizenry can and should get similar treatment without placing the entire cost upon the already burdened shoulders of Government funds.

The advantages to the welfare of the Nation as a whole, under these bills, are many. Everyone under H. R. 4312 and H. R. 4313 would be able to get preventive, diagnostic, and curative medical service, the importance of which no one can honestly dispute. The lessons learned in World War II substantiate and inflate the significance of these three types of medical treatment. Col. Leonard G. Rountree, M. D., Chief of the Medical Division of the Selective Service System, stated that 700,000 out of 4,200,000 4-F's were rejected for remediable defects.[4] In other words, one out of every six men who were rejected could have filled the gaps in the armed services had preventive medical service been available and curative medical services administered. In addition, the United States Public Health Service compared the records of a group of rejectees with the records of these same men while they were in school 15 years before. Most of the diseases and defects which caused rejection existed in childhood but had not been cared for.[5] With billions of dollars being appropriated for defense, part of which is for the maintenance and scientific research of implements of war, it seems ironic that anyone should fail to realize that the men who will use these weapons must also have the optimum in medical research and physical maintenance made available to them. Man is far less expendable than are machines. Or doesn't this Congress believe that?

METHODS OF PAYMENT AND COST

It appears that the most controversial issues of these bills hinge upon method of payment and cost. If we require people to take a pauper's oath before they can get medical attention, we are defeating the purpose of national health insurance legislation. Furthermore, thousands of social workers would be needed to investiagte financial status of each family and to maintain a check on their financial status. This would create a bureaucracy in itself—the very thing opponents of these bills claim they are trying to avoid.

We are solidly against any system of medical insurance based on charity. We should follow the example of social security, in effect since 1935, and permit the great mass of self-supporting, self-respecting wage earners and their families to pay their own way.

The Committee for the Nation's Health is now distributing a report on the cost of national health insurance prepared by Mr. George Soule, economist. Mr. Soule estimates that the national insurance program could cost for the first year or two $5,500,000,000 at the most—a little more than is now already being paid by the general public for inadequate medical care. This estimate provides for a 25 percent increase in the income of doctors, based on the theory that they could, by being fully employed (especially the younger ones who aren't presently 100 percent employed), provide 25 percent more medical care. Soule reports that "higher estimates made by such groups as the AMA would require more doctors, hospitals, dentists, nurses, and other health personnel than now exist or else payments to these people would be far above their present earnings." He illustrates this by saying that the AMA's estimate of $18,000,000,000 would mean an average gross income for doctors of $80,000 a year, many times what they are earning today.[6] Cost estimates can be manipulated to any desired level. A fair appraisal of cost, we believe, should be based on past experience. Again, we refer you to the history of social security.

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[3] The Struggle Ahead for Health Insurance, Daniel F. Cleary.

[4] Hearings before a subcommittee of the Senate Committee on Education and Labor, on Senate Resolution 74, pt. 5, July 1944, pp. 1635–1637.

[5] Child Health and the Selective Service Physical Standards in Public Health Reports, vol. 56, No. 50, December 12, 1941, pp. 2365–2375.

[6] Health Insurance News from the Committee for the Nation's Health, May 1949, p. 3.

CONCLUSION

In conclusion, we should like to comment favorably on special aid for rural and other shortage areas as provided for in title IV, part A of these bills. Such provisions would place more doctors at the disposal of rural dwellers through grants and loans guaranteeing income to doctors, dentists, and others who practice in such areas, and through aid towards the travel costs of these persons and their families. Such incentives are exactly what is needed to correct the shortages in medical aid and equipment prevalent in many rural areas throughout the United States. These provisions demonstrate that there are some elected representatives who think that medical attention and service is a "right" and not a privilege; that the highest medical standards found in one locality of our Nation should be the minimum standards for the Nation as a whole.

We believe that national health insurance is destined to take its part in America's future. We sincerely hope that this, the Eighty-first Congress, can be given credit for having enacted into law the progressive legislation contained in H. R. 4312 and H. R. 4313.

APPENDIX A

Resolution 2A–48–16—Public Health

Whereas, proper medical, dental, and hospital services are necessary to assure good health; and

Whereas these services are not available to all citizens to the extent necessary to maintain a healthful nation; and

Whereas a national health insurance and public health bill has been pending in Congress for more than a year which would provide a system of health insurance and public health aid including within its scope approximately 85 percent of the population of the United States; and

Whereas it appears that concerted action on the part of the general public will be necessary to bring about action by Congress on this vital legislation; and

Whereas the Communications Workers of America has previously supported the national health insurance and public health bill: Now, therefore be it

Resolved, That this position again be made known to the appropriate Congressional leaders by the CWA president: Be it further

Resolved, That through the division legislative directors, members be urged to contact their congressional representatives to make this position known and to urge them to enact this legislation.

STATEMENT OF DR. CHESTER D. SWOPE, CHAIRMAN DEPARTMENT OF PUBLIC RELATIONS, AMERICAN OSTEOPATHIC ASSOCIATION, ON H. R. 4312 AND 4313

Mr. Chairman and members of the committee, I should like to express on behalf of the American Osteopathic Association our sincere appreciation for the opportunity of making this statement on bills H. R. 4312 and H. R. 4313 entitled "National Health Insurance and Public Health Act."

The American Osteopathic Association is a federation of divisional societies in the respective States and is organized on democratic lines. Its policies are determined by a house of delegates chosen by the divisional societies, which meets annually. The next meeting of the house of delegates is scheduled for the week of July 11 at St. Louis, Mo., in fifty-third annual convention.

There has been no opportunity for the house of delegates to pass on these bills, but similar bills in previous Congresses have been considered in the conventions in recent years, and the department of public relations acting under the direction of the interim governing body the Board of Trustees has therefore considered the pending bills in the light of policies heretofore established. We will delineate those policies in detail at the time of our appearance on title VII of the pending bills. For over-all purposes, at this time, suffice it to say that it is and has been the consistent policy of the American Osteopathic Association to offer active cooperation for the promotion and execution of any sound health plans instituted by Government or private sources, whether the plans be supported by voluntary or compulsory prepayments, although preference has been expressed for a single national prepayment plan supported by taxation as affording the nearest to complete and comprehensive coverage.

The pending legislation has two primary objectives. First, to increase the supply and cure the maldistribution of health personnel and facilities. Second, to make the services of health personnel and facilities available to the people on a tax prepayment basis.

The first six titles of the legislation are devoted to the first objective. These titles relate to education of health personnel, medical research, increased hospital construction, special aid for rural and other shortage areas, grants to States for State and local health work, and research in child life and grants for maternal and child health and crippled children's services. It is our understanding that these titles are to be taken up separately at which times we will be given the opportunity to express our views in relation to each.

The second objective would be proposed to be accomplished under the provisions of title VII which deals with prepaid personal health insurance benefits. As I have already stated, we will expect to express ourselves in detail on this subject when that title is specially before your committee.

In connection with both these primary objectives, the osteopathic profession and institutions which serve an increasing segment of the population necessarily occupy an important and responsible position.

Congress is the architect of the plan, but if the program is to succeed nothing should be left undone to insure the harmonious cooperation of the workers who must render and furnish the services involved.

Under a tax prepayment plan, the taxpayers would be entitled to the health services as a matter of right. The right to choice of physician under such circumstances takes on a meaning of broad significance. Some sources glibly employ the term "choice of physician" while at the same time restricting that choice to a particular school of practice. Due to the comparatively large number of allopathic physicians in practice (there are about 15 allopathic physicians to one osteopathic physician) the welfare of their patients is sometimes subserved in legislation without comparable concern for the welfare of the patients of other schools of practice. This discrimination is aggravated by the creation of government medical advisory committees which confine representation entirely to representatives of allopathic practice.

An osteopathic patient whose pay roll is taxed for prepayment of health care costs would be deprived of his rights if the osteopathic physician or surgeon or the osteopathic hospital were denied participation under the plan. In addition, he would have to pay twice for the service.

Furthermore, it certainly would not be the democratic way, if Federal legislation were to destroy competitive enterprise among the healing arts and establish a single system of State medicine. Safeguards against such a contingency are a must in any national health legislation.

Osteopathic physicians or surgeons are licensed and practicing in all the States, in numbers about 11,000, in excess of 8,000 of whom are members of the American Osteopathic Association. Approximately half the States grant licenses to osteopathic applicants to practice the healing art in all branches including obstetrics, drug therapy, and major operative surgery. In most of the remaining States osteopathic physicians are registered under the Harrison Narcotic Act and are entitled to practice minor or major surgery. In excess of 300 hospitals staffed by osteopathic physicians or surgeons are located throughout the United States.

Most osteopathic physicians are engaged as general practitioners. However, an increasing number are engaged in the surgical and other specialties. Specialty boards issue certifications after the most exacting requirements.

These general practitioners and specialists of the osteopathic school of medicine are rendering general and specialty out-patient or in-patient service throughout the country under authorizations from the Veterans' Administration, as physicians.

Previously in these hearings a member of your committee asked the Acting Federal Security Administrator, Mr. Kingsley, who was then testifying, whether osteopathic physicians were contemplated as participants under this legislation and his answer was that the bill was vague in that respect. That statement in and of itself imputes ambiguity to the term "physician" as used in the bills.

Congress defined the terms "physician" and "medical, surgical, and hospital services and supplies" in the United States Employee's Compensation Act expressly as inclusive of services and supplies by osteopathic practitioners and hospitals within the scope of their practice as defined by State law (Public Law 558, 75th Cong.). Inclusion of a similar definition in the pending legislation is imperative in the public interest, in justice to osteopathic patients and in fairness to the osteopathic profession and institutions.

DEPARTMENT OF AGRICULTURE,
OFFICE OF THE SECRETARY,
Washington, May 19, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

DEAR MR. CROSSER: This is in reply to your request of April 26, 1949, for a report on identical bills (H. R. 4312 and H. R. 4313) to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes.

Title VII of these bills is quite similar to H. R. 783 on which we expressed our views in the letter of April 21, 1949. We note, however, that the section on rural areas, section 256 of title II of H. R. 783, has been elaborated into an entire new title, title IV, in H. R. 4312 and H. R. 4313. We are glad that this title, which recognizes the disparity in health services between rural and urban areas and calls for special consideration to the acute health problems of rural and other shortage areas, is included in the proposed legislation. It seems especially appropriate that in title IV assistance is authorized to farmers' experimental health cooperatives, since it will give such groups an opportunity to demonstrate to what extent they are able to provide comprehensive medical care to their members. The grants and loans authorized in title IV also should be very helpful to rural areas as they attempt to overcome shortages in health personnel and facilities.

A number of other titles would authorize needed educational and research programs, and assistance for State and local health work and for various child health and crippled children's services. While we have not studied these other titles carefully, they also appear to be intended to authorize useful health activities of various sorts.

This Department recommends passage of the proposed legislation.

The Bureau of the Budget advises that enactment of the proposed legislation would be in accord with the program of the President.

Sincerely,

CHARLES F. BRANNAN, *Secretary.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., May 24, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CROSSER: Reference is made to your letter of April 26, 1949, requesting a report by the Veterans' Administration on H. R. 4312 and H. R. 4313, Eighty-first Congress, identical bills each entitled "A bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes."

The purpose of the proposed legislation is as set forth in section 2 of the bills under the heading "Declaration of purpose." Briefly, the measures are related to the recommendations of the President of the United States as contained in his message to the Congress of April 22, 1949, advocating the enactment of a comprehensive national health program with the following broad objectives:

1. A Nation-wide system of health insurance.
2. Expansion of medical schools with construction of teaching hospitals and other facilities and scholarship aid.
3. Provision for increasing Federal aid for the construction of hospitals and other medical facilities.
4. Increased Federal grants to States and local governments for prevention and control of certain diseases, promotion of maternal and child health services, services for crippled children and general public health activities.

The massage also recommended expansion and improvement of medical research.

The bills would not be administered by the Veterans' Administration and accordingly, no effort will be made in this report to analyze their detailed provisions. One provision of interest to the Veterans' Administration is that the National Council on Education for Health Professions, authorized by the amendment contained in section 102 (a), shall have as one member the chief medical officer of the Veterans' Administration or his representative.

It is noted that in connection with the proposed scholarship program provided until title I, it is specified that no scholarship will be awarded to any person for any period during which he is receiving education or training under the Servicemen's Readjustment Act. The Servicemen's Readjustment Act program of education and training is applicable to veterans of World War II and, depending upon the length of their service, may amount to a maximum of 4 years' training. In general, the educational program under the Servicemen's Readjustment Act is limited by a final cut-off date of July 25, 1956, so that with certain exceptions education and training cannot be afforded under that program beyond July 25, 1956. No reference is made in this provision of the bill to disabled veterans of World War II who may be receiving rehabilitation training under Public Law 16, Seventy-eighth Congress, as amended, which type of training is likewise circumscribed by the terminal date of July 25, 1956.

While the bills provide for appropriations to defray at least part of the cost of the health insurance program, nothing is stated specifically with reference to whether a portion of the cost will be met by contributions from employees. In the event it is contemplated that those to be benefited shall contribute to the necessary fund, it should be observed that this would apparently involve contributions by veterans toward certain benefits to which they may already be entitled under existing law. The present law provides, in general, for hospitalization and medical care for veterans with service-connected disabilities who meet the necessary service requirements. Further, it is provided that war veterans and a limited class of peacetime veterans, otherwise eligible, may be entitled to hospitalization, including medical care, for non-service-connected conditions if beds are available. In these cases of war veterans with non-service-connected conditions, there must be filed an affidavit that they are unable to defray the necessary expenses.

The proposals contained in these bills would not appear to be designed to impair in any way the system of hospital benefits and medical care now administered by the Veterans' Administration in behalf of veterans.

I do not conceive it as being within the compass of my authority or responsibility as Administrator of Veterans' Affairs to undertake the recommendation of any particular plan for meeting the over-all problems of the Nation in the field of hospitalization and medical care. Under the circumstances, therefore, no further comments are presented concerning this proposed legislation.

Advice has been received from the Bureau of the Budget that the objectives of this legislation are in accord with the program of the President.

Sincerely yours,

Carl R. Gray, Jr., *Administrator.*

Statement of Secretary of Labor Maurice J. Tobin

I appreciate very much this opportunity to state my views to this committee on H. R. 4312 and H. R. 4313, the National Health Insurance and Public Health Act. This highly important legislative proposal deeply affects the well-being of virtually all of our citizens and is a proposal which I hope will receive early and favorable consideration by the Congress.

The Department of Labor is vitally interested in any proposal to improve the health of the workers of this country as a means of increasing both their productivity and general well-being and the welfare and security of the Nation as a whole.

The impact of ill health on American production is startling and frightening in its implications. In a crucial period of our country's history—1942, the first full year of war, when full production was particularly urgent—illness of one kind or another cost American industry 4,000,000,000 workdays. This unbelievable total of lost workdays was equal to the loss of a full year's working time of 13,000,000 people—a manpower force considerably greater than the total strength of our armed forces at that time. Of these lost workdays, 500,000,000 were due to absenteeism, caused by illness or accident, a billion to permanent disability, a billion and a half to premature death, and another billion to the reduced efficiency of persons who remained on the job although actually too sick to work. It has been estimated that, on any given working day, over 7,000,000 persons in the United States are so disabled by sickness or injury that they cannot go about their ordinary business, and that, of this number, about half have been disabled for 6 months or more. Many others conduct their daily affairs while suffering from physical or mental afflictions which affect their efficiency and, consequently, their productivity. In terms of dollars and cents, American industry and American workers lost, it is estimated, approximately $15,000,000,000 in 1943 through workers' sickness and disability.

These figures are shocking, especially when they are considered in the light of this country's preeminant economic position. At present we possess technical resources and equipment without equal. Our medical profession fortunately is composed of men devoted to the highest standards of the practice of medicine. We have achieved tremendous advances in scientific techniques for the prevention, diagnosis, and cure of disease.

Considerable public funds have been expended—and properly so—for these purposes. It is only right that the advancements in medical science resulting from the expenditure of public funds should be made available on a widespread scale and thus accrue to the benefit of all of our citizens. Unfortunately, however, our medical know-how is not available to a large part of our population. As the President stated in his message of April 22, 1949, to Congress urging the adoption of national health legislation:

"As medical examination and practice have become better, they have become more specialized and at the same time more expensive. As treatment has become more expensive families have found it more and more difficult to meet the extraordinary costs of accidents, serious illness or major surgery. Thus at the same time that our knowledge of how to provide medical care is at its highest point, more and more people are unable to afford it. It is no longer the poor who are unable to pay for all the medical care they need—such care is now beyond the means of all but the upper income groups."

Despite the clear and convincing evidence that a substantial part of our Nation suffers from ill health or disability, the claim is still being made that "an American system of medicine of a higher standard than is enjoyed anywhere else in the world has been developed and continues to progress." This assertion is plainly refuted by available statistics, which show that in the years immediately preceding World War II, 7 countries had lower infant mortality rates than the United States, from 7 to 11 countries had lower death rates among children and adolescents and 20 or more countries had lower death rates among persons aged 35 to 64, depending upon the age group. Further, it cannot be gainsaid that our efforts to curb noncommunicable diseases have not matched our achievements in the prevention and control of epidemics of contagious diseases, which, incidentally, have been achieved to a great extent through measures of public sanitation.

Even if we discount the foregoing comparative figures on death rates in the United States and in foreign countries, there is no cause for smug satisfaction with the national health in view of our resources and skills. The appalling statistics as to the number of persons rejected by selective service during World War II as unit for military duty should give us pause. Many of them were simply victims of civic apathy. Over 4,000,000 men of draft age were finally classified IV–F even after being reexamined under the revised Army and Navy physical and mental standards which were lowered pursuant to the recommendations made by a special commission of physicians appointed by the President. During the last calendar year of the war, despite the need for manpower and the relaxed standards adopted by the armed forces, 37.6 percent of the men examined for the first time were rejected. That these selective-service figures fairly reflect the state of the Nation's health is demonstrated by the results of the national health survey conducted by the United States Public Health Service in 1935. This study found that 23,000,000 people in this country were suffering from a chronic disease or from some physical impairment. I venture to say that the economic and emotional strains of the past decade and a half have not improved the Nation's physical or mental condition.

In part, poor health is spawned and fostered by substandard social and economic conditions. But ill health is also caused by a shortage of medical facilities and personnel in some geographical areas, particularly rural regions, and by the lack of a proper system of prepayment for medical care in those areas enjoying more adequate medical facilities.

The proposed National Insurance and Public Health Act provides an effective vehicle for remedying the defects and inadequacies of our present system of providing medical care for our people. It is a well-conceived program which will insure a vast improvement both in the quality and quantity of medical services and in the distribution of these services to all segments of our population.

I shall now discuss those particular provisions of the bill in which the Department has a direct interest. Title I of the bill, providing for grants-in-aid to schools for the education of health personnel and grants to States for practical-nurse training, will provide for an increased number of technically skilled persons which is essential for carrying out an expanded health program.

The purpose of title II, which provides for the extension of Federal medical research activities cannot be too highly praised. There is still much that remains to be done in solving the problems encountered in the prevention, treatment, and control of diseases in which the death rate has increased rather than decreased in recent years.

Title III would liberalize the provisions of the Hospital Survey and Construction Act of 1946 by increasing allotments to the States for costs of construction of hospitals with emphasis on facilities for group medical and dental practice. This would constitute another necessary and important part of the program to provide adequate medical care. Surveys of the Bureau of Labor Statistics indicate the likelihood that future hospital construction can be accomplished more economically in view of recent reductions in the cost of building materials and the increasing competition of public contracts. This would therefore appear to be an appropriate time to increase allotments to take advantage of these reduced costs. There is a very great need for new facilities authorized by the title.

I approve the program set forth in title IV which provides for the relief of shortages in rural and other areas by guaranteeing the income of professional personnel who settle in rural areas, and by grants and loans for the cost of medical facilities, including the construction and equipment of health centers.

Title V further develops already existing programs for grants to the States for adequate public health services. I am in favor of this program. It will be a necessary supplement to the health-insurance program of title VII in that it will provide health services, such as the prevention and control of certain of the more dangerous diseases and measures for improvement of sanitation, which are not otherwise available.

Title VI, providing for research in child life and grants to States for maternal and child health and crippled children's services constitutes an effective framework for the development of a coordinated program which should greatly improve the health and welfare of children of this country. It should be helpful in supplementing the Department of Labor's activities with respect to child labor and youth employment. In providing for the program envisaged by title VI, I interpret the provisions of the bill not to interfere with the primary responsibility of the Department of Labor in the fields of child labor and youth employment.

Title VII constitutes a far-reaching and forward-looking advance in the field of health insurance and is, in reality, the instrumentality in this bill which will render medical assistance available to all of our citizenry. This is the title under which medical care is extended to the many millions of our people. It provides for a decentralized administration of an insurance plan under which is safeguarded the freedom of both professional practitioners and patients to enter into, or remain in, a relationship of doctor and patient.

As the Ninth Annual Report of the Social Security Board noted:

"The United States is unique among the major industrial countries of the world in that it has no systematic general provision for offsetting loss of earnings when a worker is sick or disabled or for assuring that adequate medical care is available for persons who require it, regardless of their ability to pay for such care at the time they need it. Throughout the war years, as in all times except periods of widespread unemployment, the losses and costs attributable to disability have been the greatest single cause of poverty and dependency in the United States."

According to a study of the Bureau of Labor Statistics of family income and spending, average annual expenditures for medical care by families of two or more persons in cities in 1944 were as follows:

Income	Percent of families in each class	Cost of medical care	Income	Percent of families in each class	Cost of medical care
Under $500	3.3	$62	$2,500 to $3,000	16.4	$123
$500 to $1,000	11.5	88	$3,000 to $4,000	14.2	149
$1,000 to $1,500	9.1	94	$4,000 to $5,000	7.7	190
$1,500 to $2,000	14.4	105	$5,000 and over	6.2	265
$2,000 to $2,500	17.2	104			

It can be readily seen from these tables that the higher-income groups are able to spend considerably more on medical care than are the lower-income groups. Yet the percentage of income spent on medical care by low-income groups is greater than that spent by high-income groups. But this does not tell the whole story. Plainly, the dollar expenditures for medical care are a far heavier burden to the low-income groups where elementary necessities such a food, shelter, and clothing take a much larger percentage of their income than is true in the case of the upper-income groups.

Let me make it clear that the low-income groups are not the only people suffering a lack of proper medical care. The middle-income groups are equally inadequately serviced. These groups are unable to qualify for charity treatment at private hospitals or public clinics despite the fact that very often the increasing cost of necessary medical care is beyond their reach. Increases in their income have been taken up by increases in the cost of living generally, leaving them little margin to meet the increased costs of medical care.

Great as is the financial burden of medical care on middle- and low-income groups, the money spent by them for this purpose does not begin to meet their needs. Statistics show that the days of disability per person rise as the annual income of a family falls. Similarly, the incidence of illness and disability in any given area is high where economic conditions are low. Thus the percentage of selective serivce rejectees form the Southern States which are largely rural was higher than for the rest of the Nation. That the lack of income is a real barrier to adequate medical services is convincingly demonstrated by the statistics presented to the Senate in 1946 by Dr. Mountin of the United States Public Health Service as to the average number of calls for physicians and dental and hospital visits made by families with annual incomes varying from under $1,200 to $10,000 and over (hearings before the Senate Committee on Education and Labor, 79th Cong., on S. 1606, pt. i, p. 147). There is, of course, a steady increase in calls and visits in proportion to the size of the family income. I should also like to stress the fact that while people in the middle-income groups may make more calls on medical services, the financial burden on them is even greater than for persons of low income because they cannot secure the free service given to the poor as charity.

The results of inadequate medical care are not difficult to foresee. Many persons, since they can ill afford medical care, rather than incur the burden of such expenditures, keep on working or going about their ordinary business, and thus neglect to treat their ailments. As a result, not only is there a loss of efficiency, but often the ailment becomes progressively worse and requires much more drastic treatment or results in a permanent disability. We can no longer afford to be as wasteful of our manpower resources as we have been in the past.

It should be noted here, parenthetically, that the statistics cited above showing the average cost of medical care do not take account of the fact that illness is usually unexpected and unpredictable. Unfortunately, many families are faced with a far heavier than average burden of medical and dental costs which may in a short time wipe out savings accumulated over many years.

In my opinion, the only real solution of the problem of financing medical care for all of our people lies in the establishment of a system of compulsory national health insurance such as is set forth in title VII of the proposed National Health Insurance and Public Health Act. As has already been pointed out, similar systems have been in sucessful operation in other major industrial countries. It would not only relieve families of the financial burden of sudden illness—a double burden in that it involves both loss of wages and extraordinary medical expenses—but it would also encourage workers to secure immediate treatment of injury or sickness and, hence, minimize the possibility of subsequent periods of protracted disability.

Health insurance should be Nation-wide so that the less prosperous sections of the country may benefit. It should also be compulsory. Voluntary prepayment medical-insurance plans have not been able to meet the country's need. These plans are necessarily more costly than the arrangements which could be worked out under the proposed plan where there would be a wider sharing of the risks and where the administrative economies inherent in handling larger units would be possible. Furthermore, such membership in voluntary plans is as yet limited mostly to middle-income families in cities. According to one of the proponents of such voluntary plans, their coverage in 1946 did not include more than one-sixth of our population. Moreover, such plans usually cover only certain types of medical costs, such as hospital bills, but do not cover doctors' fees, which customarily constitute the greatest percentage of one's medical expenses. Millions of our people are barred from participating in voluntary prepayment medical insurance because they happen to have had some illness of a serious nature in the past or are afflicted with a chronic ailment or a physical defect. Because of these limitations in the voluntary prepayment insurance plans it is essential for the welfare of all our people that a system of compulsory health insurance be provided.

Our experience in the administration of old age and survivors insurance should prove of invaluable aid in establishing a program of national health insurance. And, I should like to stress this fact—that it is an insurance system and it is not a system of State regimented medicine.

The health and vitality of our people, particularly in the light of present world conditions, demand prompt adoption of an effective program of health insurance. The proposed program is designed to safeguard the Nation's health and it can accomplish this end within the framework of our existing political, social, and economic system. I, therefore, urge this committee to report favorably on the bill.

In addition to the general comments which I have given above on H. R. 4312 and H. R. 4313, I would like to file with the committee a memorandum concerning certain technical changes which the Department of Labor believes should be made in these two bills.

MEMORANDUM OF UNITED STATES DEPARTMENT OF LABOR ON PROPOSED CHANGES IN TECHNICAL PROVISIONS OF H. R. 4312 AND H. R. 4313, NATIONAL HEALTH BILLS

I. Fair labor standards in construction of health facilities

There are a number of provisions in the proposed "National Insurance and Public Health Act" which authorize Federal grants either to the States or to private nonprofit agencies or institutions for the construction of health facilities. Section 373 in title I authorizes appropriations for grants for construction and equipment to assist in the establishment of new schools and improvement and expansion of existing educational facilities. Title III amends the Hospital Survey and Construction Act which provides for grants to the States in aid of the construction of hospitals. Section 402 in title IV authorizes grants and loans to persons for the cost of construction of health centers, or clinics or of facilities for group practice and for loans for cost of facilities (including construction) to qualified professional and technical health personnel.

It is essential that, in all construction financed by the Federal Government, fair labor standards be maintained. While some of the above provisions are adequate in this respect, others are not.

Title III preserves the already existing protection of labor standards in hospital construction in section 625 (a) (5) (ii) of the Hospital Survey and Construction Act, which incorporates by reference the prevailing wage rate provisions of the Davis-Bacon Act of August 30, 1935, c. 825, as amended (40 U. S. C., sec. 276a). The provisions of section 625 are applicable to all construction under title III and are expressly made applicable to the construction of "hospitals" pursuant to section 373 in title I by subsection (b) of that section. But the conditions for receipt of grants for construction of other health facilities under title I (such as the cost of a new medical school building) do not include the maintenance of labor standards.

In establishing policies for making grants and loans under section 402 of title IV, the National Health Insurance Board is directed in section 403 to "take into consideration policies and requirements contained in or established under" the Hospital Survey and Construction Act, which provides for payment of prevailing wages by contractors. This directive would not appear to make the establishment of fair labor standards mandatory upon the National Health Insurance Board. To "take into consideration" does not necessarily mean to follow. Subsection (b) of section 403 provides that if any person to whom a loan for the full amount of the cost of construction of a facility under paragraph (D) or (E) of section 402 (a) (1) has been made subsequently applies under title VI of the Public Health Service Act (the Hospital Survey and Construction Act) for Federal aid, the application may be approved although made after construction is completed, if it is in compliance with the requirements of section 625 (which includes payment of prevailing wages). While section 403 (b) would apply to some of the construction aided in section 402, it would not apply to construction on which no application was made under section 625.

Because of the inadequacy of their provisions for labor standards in construction work, I am of the opinion that both title I and title IV should be amended by the insertion of provisions similar to that contained in section 625 (a) (5) (ii) of the Hospital Survey and Construction Act (see page 55 of H. R. 4312). This could be accomplished by adding to subsection (a) of section 374 a paragraph (3) containing such language and by adding a subsection (c) to section 402 making the assurances contained in section 625 (a) (5) (ii) a condition for all grants or loans for construction under that section.

II. Industrial hygiene activities

The declared purpose of title V of H. R. 4312 and H. R. 4313 includes assistance to States in developing health services, including the prevention and control of occupational diseases and the improvement of sanitation and other environmental factors affecting health (sec. 501). Under the proposed section 316 (a) of the Public Health Service Act, the Surgeon General is authorized to prescribe the percentages of allotments which may be withheld from a State unless the State plan includes provisions for the prevention, treatment, and control of various specified diseases and of "any other disease, or category of disease"—a term which might possibly include occupational diseases—and the improvement of sanitation and other environmental factors affecting health. The grants under this title would presumably be made to State health authorities.

These provisions might be interpreted to authorize grants to State health departments for industrial hygiene and, perhaps, even industrial safety purposes. This would result in a duplication of the work of State labor departments which have long had jurisdiction over industrial safety and industrial hygiene programs. Grants made by the Public Health Service in the past to the States for industrial hygiene purposes under the general authority of the Social Security Act have been recently criticized by the Commission on Organization of the Executive Branch of the Government. As stated by the Commission:

"The recent Federal policy in grants to the States for industrial hygiene work has created serious imbalance in State programs and is closely related to established Department of Labor functions and programs. The Public Health Service administration of grants to State health departments on a 2-for-1 basis has led the States to build up their health departments and to let the industrial hygiene work of their labor agencies atrophy. This is a serious situation inasmuch as the actual inspection and administration of industrial hygiene and labor standards generally is traditionally part of the State labor agencies' factory inspection and labor work generally."

For these reasons, I would favor the insertion of a provision in title V that it does not authorize grants for industrial hygiene or industrial safety activities.

United States Maritime Commission,
Office of the Chairman,
Washington 25, D. C., June 9, 1949.

The Honorable Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

My Dear Mr. Crosser: You have my notice of hearing inquired whether the Commission desires to testify or file a statement on H. R. 4312 and H. R. 4313, identical bills to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes.

These bills would provide Federal grants for medical research, training and education, and numerous other aids for the improvement of medical science as well as benefits to individuals consisting of medical, dental, nurse, hospital, and auxiliary services on an insurance basis. The bills do not involve matters within the jurisdiction of the Maritime Commission, and only concern the activities of the Commission as they affect Maritime personnel in connection with water transport in offshore operations.

Section 322 of the Public Health Service Act (58 Stat. 682), which provides for the care and treatment of merchant seamen, is not affected by these bills. This service dates back to 1798, when Congress established marine hospitals, the principal purpose of which was to provide medical treatment for seamen. Seamen now, under certain circumstances, are entitled to hospital, dental, and medical care without cost in case of illness or injury.

Under present United States Public Health Regulations, a seaman injured in the service of his vessel may receive free medical care at a Public Health Service hospital or station. This treatment must be secured during employment or if a seaman has completed 60 or more days' employment, then within 90 days of such employment. The treatment is not necessarily available on a service-connected disability theory since an injury, manifesting itself after the established period, will not enable the seaman to secure treatment, regardless of medical proof that the illness or injury was service connected.

Merchant seamen would be covered by section 704 of the bills (p. 109), which in summary provides that every individual shall be eligible for benefits if he has received wages in the amount and during the period prescribed in said section, or is entitled to benefits under title II of the Social Security Act.

Merchant seamen are specifically mentioned in section 781, which defines the term "employment" as used in the bills, as service in connection with an American vessel under a contract made in the United States or during the performance of which the vessel touches a port in the United States (pp. 156–157).

An American vessel is defined in the bills as a vessel documented under the laws of the United States, including a vessel whose crew is employed solely by a citizen of the United States (sec. 781, p. 160).

Under the provisions of these bills, individuals and their dependents, including Maritime personnel, who are insured as therein provided, will be required to pay for the benefits in proportion to their income (sec. 3, p. 9).

Merchant seamen, however, would, under these bills, be eligible for more extensive health services than now available to them under existing Public Health Service and other laws, and the benefits of the bill would extend to seamen's dependents who are not now eligible for benefits accorded to the seamen themselves.

The Commission does not propose to testify at the hearings, but will, however, keep advised as to the progress thereof with reference to seamen, and if it seems advisable, submit any factual comments which may appear to be pertinent to the record.

Sincerely yours,

PHILIP B. FLEMING, *Chairman.*

STATEMENT ON NATIONAL HEALTH INSURANCE BILLS (H. R. 4312 AND H. R. 4313) BY RUSS NIXON, WASHINGTON REPRESENTATIVE OF THE UNITED ELECTRICAL, RADIO, AND MACHINE WORKERS OF AMERICA (CIO)

The United Electrical, Radio, and Machine Workers of America, representing 600,000 workers in the electrical manufacturing industry of the Nation, reiterates its strong support for the national health insurance program which we endorsed to this committee during the Seventy-ninth and Eightieth Congresses. H. R. 4312 and 4313 should provide the essential first step in getting that program started.

This legislation, best known to the American people as the Wagner-Murray-Dingell bill, has been before Congress in one form or another for 6 years or more—at least since its introduction in the first session of the Seventy-eighth Congress. That was in 1943. We were at war, and the Nation was shocked to find that 40 percent of our potential military manpower was unfit for active service. The facts were diligently gathered and put in the record by Senator Pepper Subcommittee on Wartime Health and Education. Since then, the Nation has waited to see when Congress would exercise its responsibilities. This should have been one of the first of last year's "Fair Deal" election promises to be fulfilled by the Eighty-first Congress.

As things stand, however, it is common talk in Washington that national health insurance hasn't a chance in this Congress, that it is too costly, too controversial, that the most we can expect is some funds for research, perhaps some new hospitals. It seems incredible that a Nation which can afford $15,000,000,000 a year for military defense cannot find an additional $4,000,000,000 a year or so to defend the health of its people.

There are two simple groups of facts which stand out and which should dissipate all argument. They are:

(1) Every year, 325,000 people died whom we have the knowledge and skills to save; every year the Nation loses over a billion man-days of work through illness; every year more than 10 percent of our potential production and income is lost through sickness and disability;

(2) Barely one-fifth of our people can afford adequate medical care; half our families can afford a doctor or hospital care only in extreme emergency; an additional 30 percent of families can meet the cost of illness only by going into debt or sacrificing property and savings.

In this connection, it is distressing to find the Department of Labor, in its recent book, The Gift of Freedom, informing workers abroad that although there is no comprehensive sickness insurance plan in the United States, "voluntary group action has provided a substitute for an increasing proportion of the population"—more than 25 percent in 1947.

The prepayment and commercial insurance plans referred to by the Department of Labor are in no sense a "substitute" for comprehensive sickness insurance. The Department of Labor would have done better to face honestly up to the facts. The facts, as stated by the Federal Security Administrator in his Report to the President on the Nation's Health, are that "less than 3 percent of the population has anything approximating comprehensive insurance protection."

The UE is one of the unions which has taken the lead in attempting to negotiate health-benefit programs for its members. The UE program is described in Department of Labor Bulletin No. 841, Health-Benefit Programs Established Through Collective Bargaining. The UE is proud of the fact that 1948 contract provisions provided health insurance for 137,000 workers in 461 plants. The program generally provides benefits up to $35 or $40 per week for periods up to 13 weeks per illness or disability. Surgical reimbursement is generally provided up to $150 per operation, and hospitalization, up to 30 days per year.

But we do not claim that such a program is more than a stop-gap until a comprehensive national program is enacted. The thing that eats up a worker's income is the cost of adequate medical care for himself, his wife, and his children—the routine medical care problems which mean the difference between a healthy nation and a half-sick nation. We know that provision for emergency care is insufficient; it does not prevent illness nor promote better health.

Let me give you some examples of what these national statistics mean in individual cases. Let us interview an average doctor from New Jersey who for these purposes we may refer to as Doctor X:

Take 12-year-old Tommy ——— of Paterson, N. J. "He walked into my office with his mother for the first time Saturday," Said Doctor X. "He was pale, washed out, anemic, with a heart rate of 140 and a temperature of 102. Very ill.

"Last November he took sick. He had aching pains in his chest. The trouble was diagnosed as rheumatic fever. He spent a few days in a Passaic hospital and then started going to a heart clinic. Finally a public health nurse recognized how serious his condition was, and recommended that his mother try to place him in a special hospital. Then the mother brought the boy to see me.

"He walked into my office when he should have been carried. He should have been put in bed months ago, and kept there. Irreparable damage has probably been done to his heart by failure to treat this case as drastically as necessary. The mother simply had not been given the proper advice.

"The family hasn't any money. The father is unemployed, the mother works. There are three other kids. If Tommy goes to a special hospital, it will have to be one at Atlantic City, 125 miles away. The mother hasn't money enough to visit him and she's afraid he'll get terribly depressed away from the family.

"It's the same old problem I see every day.

"A man making $50 to $55 a week has only about $25 a year to spend for medical care for his family. If the average man has to be in the hospital for 4 or 5 weeks, it will cost him anywhere from $200 to $250.

"We have advanced so far in specialized medical knowledge requiring attention by various physicians that the average patient simply cannot afford medical care on an individual payment basis.

"We could honestly practice much better, much more scientific medicine under a national health insurance plan. We could refer people to specialists immediately when they need a specialist's treatment—without worrying whether the patients individually could afford it."

Take another case:

"A man about 50 years old walks into my office and complains about pains in the stomach," said Doctor X. "Now every good doctor knows that the first thing you look for is the possibility of cancer. The patient needs an X-ray first of all.

"But an X-ray costs about $35, and frequently a good practitioner feels that the patient 'can't afford' it. If he can afford it, and the X-ray shows that there is malignant growth, then the patient may not have any money left for further treatment.

"I defy the medical societies to show that doctors generally order X-rays first in cases like this. They play around with the patient, not in any malicious or gouging way, but they play around with him. They give him pills."

What happens? The doctor was frank. "A lot of people die of cancer when they could have been kept alive by an operation—if the cancer was discovered in time!"

That's Paterson, N. J. * * * one doctor * * * his opinions. Consider Anytown * * * and John Jones, typical citizen.

"Mr. Jones," asked an interviewer, "do you have insurance to cover any hospital bills you might have?"

"No," said Mr. Jones, he hadn't.

"Mr. Jones," the interviewer continued, "do most of the people you know see a doctor when they should, or do most of them put off seeing a doctor?"

Most of them, said Mr. Jones, put it off.

"Mr. Jones," said the interviewer, "do you think there are any people in the United States who can't afford to see a doctor as often as they should?"

A great many, said Mr. Jones.

Exactly 2,523 "Mr. Jones'" scattered all over the Nation answered questions for the National Opinion Research Center of the University of Denver. And the sum of their answers shaped up like this:

Two-thirds of them said they didn't have hospital insurance.

Half of them said their friends don't see doctors when they should.

More than half of them said that they believed there are a "great many" people who can't afford to see a doctor as often as they should.

Well over half said they would be willing regularly to pay 2½ percent of their income to secure all necessary medical and hospital service.

That's what the people think about their problems.

We asked Doctor X: the people need more medical care, most of them would like to pay for it in advance through social security—how come doctors and their American Medical Association (AMA) fight the Federal health plans?

"Many of them don't!" replied Doctor X. "A Federal health plan would improve the lot of the average general practitioner. The only ones to 'suffer' would be the rich hospitals like Mount Sinai and Johns Hopkins and the Mayo Clinic and the doctors who make 50 to a hundred thousand dollars a year from wealthy patients.

"I don't think the ordinary general practitioner is fooled by AMA propaganda. But there is definite terror from above to keep him in line. I am sure the chiefs of hospitals put pressure on the doctors. Our last medical society meeting considered the $25 assessment that the AMA is collecting to fight the Federal health bill.

"There were some people there who haven't come to a meeting in the last 5 years. The meeting voted to pay the assessment, so now in effect it's compulsory. If we refused to pay, we wouldn't get an appointment at a hospital, we'd be threatened with expulsion. Our whole professional existence would be in jeopardy."

We said to Doctor X, "but the AMA does have one argument that seems to make sense to a lot of people. The AMA claims that under a Federal health plan the direct relationship between doctor and patient would be ended. The AMA says that unless doctors collect fees from each patient, the quality of medical service would decline."

"Bunk!" said Doctor X. "The average person who pays a fee directly to his doctor has no conception of the quality of service he's getting. He goes to the doctor on the recommendation of someone who has been treated before. Some of the biggest phonies in town, with the best bedside manners, have the largest practices and the largest incomes."

And Federal Security Administrator Ewing flatly said: "In many of our best university medical schools and hospitals and in many of our most famous clinics, doctors are paid salaries by the institution—not fees by the patient. Yet these institutions are famous for quality of care, probably the best to be found anywhere in the world."

The system of paying doctors out of tax funds to provide care for all the people was recently adopted in England. The English people have had a form of health insurance since 1911, but they decided to extend it so that it would protect practically everyone.

The British health service is much like our proposed Federal health plan. The National Health Service, which came into operation on July 5, 1948, provides free medical, dental, and nursing care for all who want to use it.

"Some of the swankiest hospitals now are open to the poor as well as the rich free of charge and solely on the basis of medical need. * * * In all cases, first priority on any bed goes to the patient who needs it most regardless of ability or willingness to pay," reported columnist Albert Deutsch of the New York Post from London.

And Deutsch added: "The vast majority of English people—including most members of the medical profession—do believe that it (the health service) provides something better than the 36-year-old health insurance system which serviced England until July 5, and is immensely more satisfactory than our archaic system of private fee-for-service care."

The British like a national health service—how about America? Can Government do the job?

We in the UE believe that the American people through their Government have enough ability and initiative to provide health for all the people. This we can obtain through passage and application of H. R. 4312 or 4313, the National Health Insurance and Public Health Act.

TESTIMONY OF DR. CHARLES M. THOMPSON, CHAIRMAN, LEGISLATIVE COMMITTEE, NATIONAL DENTAL ASSOCIATION, INC.

Mr. Chairman, members of the Subcommittee on Health, Senate Committee on Labor and Public Welfare, my name is Charles M. Thompson and I am a practicing dentist with offices and residence in the city of Chicago, Ill. Today I come before you as a representative of the National Dental Association, which I serve as chairman of the committee on legislation.

(Now in its thirty-sixth year, the National Dental Association is the national organization of Negroes in dentistry.) Dedicated to the highest aspects of the profession of dentistry, our association strives to improve public health, to promote knowledge of the art and science of dentistry, to advance the ideals and ethics of the profession, and to foster mutual improvement of the members of our organization and the profession generally.

Members of the National Dental Association labor in States of the Union where we are in constant contact with the people of our great Nation and in touch with the health needs of our population. It is with a sense of responsibility that we sought this opportunity to appear before your committee, Mr. Chairman, for the purpose of giving testimony on behalf of the legislation which is commonly known as the National Health Insurance and Public Health Act. Specifically, the National Dental Association wishes to take this opportunity to endorse Senate bill 1679, the administration bill.

(The National Dental Association is unreservedly in accord with the declaration of purpose of S. 1679, which describes the health of our people as "our Nation's strength, productivity and wealth." We further subscribe to the principle that the "assurance of adequate medical care to all of our people is essential to the general welfare and to the Nation's security.")

The National Dental Association takes the position that adequate medical care and precautionary health measures should be a component part of our national life and that every citizen should have a right to such not as charity, but under, shall we say, a pay-for-what-we-get plan. The health-insurance phase of S. 1679 in the Senate, and its counterpart bills in the House of Representatives, carry provisions for such a pay-as-you-go insurance. We sincerely believe that such a plan has merit.

Further, the National Dental Association condones the terms of these bills which take into consideration our national needs for more medical, dental, and allied personnel, and the dire inadequacies in the area of health and medical facilities. We approve, therefore, without reservations phases of these bills which treat segments of health education with the intention of removing causes that attribute to the shortage of physicians, dentists, nurses, medical and health technicians, and at the same time foster the establishment of research centers and medical facilities which are needed in all sections of the Nation.

It may be assumed that we testify on behalf of Negroes. Such an assumption, Mr. Chairman, we sincerely hope this committee will not take. As I have pointed earlier in this statement, the National Dental Association is interested in a national insurance plan and a national health program which takes into consideration the health needs of all the people, irrespective of race, religion, or any condition of life.

Further, Mr. Chairman, it might be assumed that our testimony is in support of fields of governmental activity which might deal specifically with health as it relates with dental health. This assumption, too, would be a false one. As dentists, we know that oral diseases cannot always be treated as matters that are distinct from the general health of a person. We know that general health is an all-inclusive problem, if I may term it such.

Then it might be assumed that as members of the National Dental Association, an organization of Negro dentists, we are interested in these bills because we feel that persons whom we represent will gain financially from the flow of additional funds into our States and localities for health welfare. In the case of Negro dentists, this would not necessarily be true. There are but a few more than 1,600 Negro dentists in the whole of the United States. The vast majority of these men have substantial practices and reasonable incomes.

Our first interest is the health and welfare of the Nation. This objective we view in a broad national prospective. Second, we are interested in the health and welfare of the minority with which we are identified. In connection with this group, we see vast lots of people who are unable to afford adequate health care. In certain sections of the country, we see social customs and community patterns which deny Negroes access to medical facilities. Then we see great shortages of medical, dental, and allied personnel among Negroes.

In addition to urging the retention of the provisions of S. 1679 which would tend toward a solution of the above ills, we stress the need of such safeguards as would assure receipt by minority groups of all of the benefits of the National Health Insurance and Health Act. We have no irreconcilable differences with regard to the location of administrative responsibility for such laws, be it local, State or Federal. But we do feel that every possible precaution should be made to assure Negroes a satisfaction of their needs in all of the areas that the prospective law covers.

The National Dental Association feels that the following items, as covered in these health proposals, are of primary concern to the Negro population of our Nation: (1) An increase of medical and dental manpower; (2) an increase of hospital facilities; (3) rehabilitation of disabled persons; (4) creation of more medical- and dental-research centers; (5) provisions for local citizens health councils; and (6) establishment of an adequate over-all health-insurance plan.

Mr. Chairman, we of the National Dental Association honestly believe that S. 1679 and its counterparts in the House of Representatives would offer adequate coverage for the national health needs of our people; that these bills are the most comprehensive that have been before the Congress of the United States; that they are administratively sound, and that they would afford a high-quality health service for our people.

The National Dental Association is on record in support of previously proposed legislation designed to improve the health of the Nation. Such legislation covered the basic principles which underline S. 1679. It is, therefore, the common and unanimous belief of our legislative committee that the membership of the association will continue to support such legislation.

We therefore endorse these bills and respectfully urge that this committee favorably report S. 1679 to the Senate Committee on Labor and Public Welfare.

STATEMENT BY H. B. ANDERSON, SECRETARY, CITIZENS MEDICAL REFERENCE BUREAU, INC., NEW YORK, N. Y.

The purpose of the Citizens Medical Reference Bureau, Inc., which I represent, is to preserve, establish, maintain, and safeguard, through publicity and other lawful means, the right of adults or, in the case of minors, the right of parents or guardians to determine the form or manner of treatment or care to be prescribed or applied for the cure or prevention of disease.

The Citizens Medical Reference Bureau, Inc., is opposed to the passage of the bills H. R. 4312 and H. R. 4313 on the ground that they would tend to deprive the individual of his inherent right to determine the form or manner of treatment or care to be prescribed or applied for the cure or prevention of disease.

These bills would have the effect of tending to deprive the individual of his inherent right to secure the treatment of his choice because—

1. They would deprive the individual of the protection he now receives by the system of checks and balances which now prevails in the regulation of the

healing art and substitute therefore a system of Federal aid which has the appearance of complying with the provisions of the tenth amendment to the United States Constitution but which actually has the effect of wiping out State lines.

2. They would have the effect of compelling all wage earners to subscribe to a highly specialized or glamourized type of medical care to be supplied to all wage earners and their families with no provision being made to supply the practitioners or treatment of choice which an estimated one-third of the population desire for themselves. Also, no consideration is given in these bills to the wide divergence of opinion within the medical profession, to the fact that medicine is an art and not a science, and to the fact that a highly specialized or glamourized type of medical care may actually result in increasing illness and mortality in this country instead of preventing it.

3. The fact that the Federal Security Agency, with an annual appropriation of approximately $167,000,000 to the Public Health Service, has today become one of the most powerful pressure groups in the Nation in support of this bill and also in support of State laws having to do with compulsory medication should serve as a warning against building up a gigantic Federal medical bureaucracy for the compulsory medical control of the individual from the cradle to the grave, which would be supplied with such enormous appropriations that Members of Congress and members of the legislatures in the respective States would be powerless to successfully combat. Some idea of the enormity of the tax funds to be provided under this bill may be gained from the fact that the national health-insurance features have conservatively been estimated to amount to $6,000,000,000 annually. Many authorities estimate that the actual cost would run several times that figure. Also, the bill combines with the health-insurance feature a public-health program estimated by the Federal Security Agency to cost in 1960 $4,107,000,000, of which $2,312,000,000 is to be supplied by the Federal Government and $1,795,000,000 is to be supplied by the States.

BILLS CONTEMPLATE A SPECIALIZED TYPE OF MEDICAL CARE

In his message to Congress April 23, 1949, President Harry S. Truman made numerous references to a specialized type of medical care. He said, "The technical resources available to the physician are tremendously greater than a generation ago. But, to make these resources effective, he must use much more complicated, more exact equipment. He must turn to specialized laboratories and technicians for help." He referred to medical education and practice as having become more specialized and at the same time more expensive. He further said, "We must keep alert to every opportunity to add to the program of medical research through new scientific techniques, such as the use of products of atomic energy, and through the wise and balanced expansion of research into diseases which have not so far been conquered."

PILLS AND POLITICS DO NOT COMBINE TO MAKE A HEALTHY NATION

In the compilation of vital statistics, no attempt is made to reveal the full extent of the illness and fatalities resulting from dangerous and unnecessary operations, habit-forming drugs, and biologic products.

In recent years the Federal Government has been much concerned with providing mental hospitals, but know of no Nation-wide survey to determine the number of persons now confined to mental hospitals whose illness was brought about through the persistent use of sleeping medicines, such as bromides, veronal, amytal, and others of the barbituate type.

Fission products have been widely distributed by the Federal Government for medical experiments in the hope of providing a cure for cancer. That radiation injury to the skin sometimes leads to cancer and that even small quantities of Roentgen or radium rays can prove damaging is brought out in an editorial in the Journal of the American Medical Association September 18, 1948, entitled "The Hazards of X-Ray." The editorial says in part:

"Think of radiation! The engineers and the nuclear physicists keep developing new apparatus. New researches, including some by the health physicists and biologists connected with the development of the atom bomb, have taught us more about the hazards of the old apparatus, also, such as X-ray and radium.

"Even small quantities of Roentgen or radium rays can prove damaging. Radiation injury to the skin sometimes leads to cancer, coming even many years after. Some of these patients did not show immediate injury, even so much as redness of the skin. Repeated or continuous irradiation of the whole body can produce aplastic anemia, sometimes leukemia, even when the individual doses have been moderate * * *.

"Roentgen treatment for benign conditions should be used only with a vivid appreciation of its capacity for harm and with an overt evaluation of its presumptive benefits weighed against the known and possible injuries inseparable from its use in effective dosage."

The extremes to which the inoculation program is now being carried for the alleged prevention of so-called contagious diseases is indicated by the following editorial in the Detroit Medical News, May 26, 1947:

"REACTIONS TO INJECTIONS

"The Gallup Poll of Public Opinion has been snooping around physicians' offices lately has discovered that we are dispensing too many 'shots.' Most injections are given for good, sound physiological reasons—others for psychogenic effects—and others—for effect.

"Diagnoses are made occasionally by history alone—the importance of physical examinations cannot be overemphasized. A patient may be advised to take a series of 'shots' and they may be administered by a nurse or an office assistant and the patient may receive treatments for weeks or months at a time without the physician ever examining them.

"Some patients look like pin cushions by the time they have had injection treatments for a cold, pains in the joints, or later, a pain in the neck. They get 'shots' for headaches, backaches and heartaches.

"Take a baby, for instance. Before she is even dry behind the ears, they give her a few 'shots' of isontonic saline in the fanny just to get her used to what's coming later. A few months later they give her whooping-cough shots, then vaccination, then diphtheria shots, then tetanus shots, then measles shots, intradermals, then allergy shots, then autogenous vaccines; then a few 'booster' shots for an encore.

"If an adolescent boy starts to develop hills where there should be valleys, he will get shots of something that causes a more manly figure to develop. If overtreated, he may have a Vandyke at the age of 12, and other physiological improvements to match.

"If an adolescent girl, she may get a few shots of some glandular extract if she seems bashful, underweight or overweight, or cries when she should be laughing—and if the menarche is a bit late they might give her some potent hormonal product that puts her on the 28-day beam and gives her the rhythmic dithers for the next 30 years.

"If she gets married and can't get pregnant, then they fill her full of antisterility shots; and, if she does get pregnant, they give her a lot more shots so she won't abort. Then, if she does stay pregnant and is a few weeks overdue, they give her another shot to put her in labor—then with the newfangled O. B. methods they give her a 'caudal,' which is 'shots' in a different spot—and some of those needles take large divots. Add to this all the shots for pain and sedation and you have 'sumpin'—and don't forget vitamin B. And also injections for hemorrhoids and varicose veins.

"Anyway, after having an average American family of 2¼ children and in a state of supreme exhaustion, she is made to submit to more injections to carry her through that alleged stormy menopause, somewhere between the ages of 40 and 80. At least that's the way we 'heerd' it. When the male of the species has reached that 'too old to dream' state, he too gets his shots to tide him over that droopy twilight period. The male, however, is more likely to associate 'shots' with 'Men of Distinction' than with parenteral therapy.

"A common tactical error in therapeutics is treating an 'anemia' with injections, without determining the cause or type of the anemia. Infrequent contact with their 'personal' physician and infrequent and incomplete physical examinations are valid reasons for any patient's dissatisfaction with the present practice of medicine. A well-cared-for and satisfied patient is the beginning of our public-relations program; and, if this factor is minimized, then all of our individual and collective efforts in Lansing, Washington, and Moscow won't do us any good

"And now—the benediction.

JAMES J. LIGHTBODY, M. D."

ASSEMBLY-LINE METHODS NOT APPLICABLE TO HEALING ART

The ability of an individual to function naturally without the use of powerful drugs or expensive and dangerous operations is a more sound criterion of the health of the Nation than the number of hospitals we are able to erect and the quantity of drugs consumed.

The practice of medicine is an art and not a science. There is a wide difference of opinion as to methods and treatment, and this difference of opinion is highly essential in view of the fact that the practice of medicine is in the stage of experiment and discovery.

The bills H. R. 4312 and H. R. 4313 are based upon the assumption that the health of the Nation is dependent upon supplying to the entire population an extensive type of medical care, which the millions upon millions of persons who adhere to religious healing, to homeopathy, to osteopathy, to chiropractic, or to naturopathic healing do not want. Also, many persons desire the services of a physician who practices a more conservative type of medical care than the highly specialized type which today is being so vigorously glamourized in the press and on the public platform.

Also, it does not necessarily require that every physician must have a premedical course of 3 or 4 years in order to be a good physician. What the requirements of the medical practice acts of the different States are to be is a matter for the States to decide for themselves.

In this connection, an item in the New York Times, May 27, 1949, reports Miss Charlotte Abbott, consultant with the United States Lutheran Resettlement Service, as saying that there were 2,500 doctors in European countries having a displaced person's status, mostly in small cities and rural areas, who are well qualified to be either general practioners or specialists.

The item further states that in North Dakota a plan has been put into effect by which DP doctors may come for a year's internship and then take their examinations. Successful candidates may be assigned to communities having no doctors under specifications from the State board. The licenses will be temporary, but may be made permanent by State-board action when a physician has become a citizen. In other States, as in Nebraska, for instance, a physician from a DP camp may practice under supervision of another doctor, as in a tuberculosis sanatorium, with the hope of an eventual license to practice independently.

It does not necessarily mean that the Nation will be a healthier Nation if the number of physicians is enormously increased. During World War II, the number of physicians in civilian practice was greatly reduced, but no major epidemic took place and the health of the Nation continued on a sound basis.

In this connection it is to be remembered that the health of the Nation is primarily concerned with the economy of the Nation, with the progress of sanitary engineering and with our standards of living.

PASSAGE OF BILL WOULD MAKE HEALTH OFFICIALS MEDICAL DICTATORS

We know of no instance wherein the Public Health Service has voiced a plea for the right of the individual to determine the form or manner of treatment or care to be prescribed or applied for the cure or pevention of disease.

In England the Ministry of Health gave its support to a provision wiping out all the vaccination laws in that country from 1867 to 1907. But in the United States the Public Health Service goes out of its way to require vaccination of all passengers entering the United States from foreign countries whether any cases of smallpox have been reported from the ports of embarkation or not. This stretching of the quarantine powers granted by Congress to that Service for use in time of actual emergency is highly questionable.

Much of the legislation passed by the States having to do with making other forms of medical treatment compulsory appears to have been inspired in large part by the Public Health Service.

This statement is supplementary to our book Public Health the American Way and our pamphlet A Reply to the Nation's Health—A 10-Year Program. These publications set forth our protest against bills H. R. 4312 and H. R. 4313 in greater detail.

TESTIMONY OF THE AMERICAN PUBLIC HEALTH ASSOCIATION ON H. R. 4312 AND H. R. 4313; ALSO ON H. R. 4918 AND IDENTICAL COMPANION BILLS

The American Public Health Association is most grateful to the chairman and members of this committee for the invitation to present testimony on the bills under discussion. I am authorized to present the association's opinion by action of its executive board after careful study of the bills. A large proportion of the asociation membership of some 11,000 are health officers and their staffs legally entrusted with the duty of devising methods to improve the health of the public. This legal responsibility for the health of the people is probably not true to an equal degree of any other professional association in this country.

We, therefore, feel not only the right but the responsibility to express our opinion regarding measures under discussion before this committee. Because our membership is especially concerned with administrative problems, we shall devote special attention to the administrative aspects which may be involved in implementing the various programs proposed.

While proud of the advances made in public health and medicine which have given the American people an enviable position in these fields, we are not content with the present situation and can see much room for improvement. The association since 1944 has held that—

1. "A large portion of the population receives insufficient and inadequate medical care" due to inability to pay costs of services on an individual basis when they are needed, or because services are not available. Distribution of costs is proposed as an important remedy for this need.
2. "There are extensive deficiencies in physical facilities needed to provide adequate services" especially in poor communities and rural areas. The construction of health centers, hospitals, and group practice facilities will supply the needed buildings, but maintenance is already a problem in many areas.
3. "There are extensive deficiencies in the number and the distribution of persons needed to provide the services" and to administer them. Training of personnel is proposed as an important remedy for this need; special inducements will also be required to improve the distribution.
4. "Expansion of scientific research is urgently needed." Financial assistance from the Government will be required to provide funds to make this research possible.

The association's 1944 statement also set forth certain major objectives: (1) to make available to the entire population all essential preventive, diagnostic and curative services—people must not be separated from medical care for economic reasons; (2) to insure that services are of highest standard, and rendered under conditions satisfactory both to the public and to the professions; (3) to extend scientific knowledge and provide for constant evaluation of the program.

We think of a national health program as something which belongs to all the people and to which all groups with special skills contribute as they are able; no program could be truly national in the American sense if it did less. We consider it highly important for all concerned—professions, the general public, and the legislators representative of both groups—to think of the health problem as a broad one. Therefore, we welcome the comprehensive approach found in legislation presently under discussion. Piecemeal legislation and attacks on categories of disease are of value, but efforts to put the pieces together into a broad inclusive program will undoubtedly be much more productive.

The conception of a broad plan obviously does not imply that all its aspects are of equal importance at any given moment. Our 1944 statement says, "Because of inadequacies in personnel and facilities, this goal (a national plan should aim to provide comprehensive services for all the people in all areas of the country.) cannot be achieved at once; but it should be attained within 10 years." Training for personnel must be provided, health facilities constructed, local public health units strengthened and extended to all areas, methods of paying for services and for equalizing financial burdens must be applied and research supported. Some priority system is needed to determine where major emphasis should be placed from time to time. People are prepared to wait for worth-while aims if they can see that steady progress is being made and that there is an over-all plan reasonably calculated ultimately to reach the goal.

The American Public Health Association believes that the Congress would be materially assisted in its deliberations on the national health program if major groups representing those providing and administering services met with consumers of health services and reached agreement on a system of priorities. The APHA has invited the American Hospital Association, the American Medical Association and the American Public Welfare Association to join in sponsoring a conference to which other professional organizations concerned would be invited as well as management, labor, farmers, and other consumer groups. There is real hope that such a conference may be useful in helping the nation find needed answers to problems of health and medical care which are so important at the present time.

PREVENTIVE SERVICES

We believe that it is imperative that plans include and emphasize the provision of preventive services for the whole population and that a most significant criterion of high quality medical care is the degree of emphasis placed upon prevention of disease. The unfortunate separation of preventive and curative medicine is incompatible with the highest standards of modern medicine.

"A national health program must include provisions for the development of full public health coverage in every area and must also integrate its medical services with the activities of public health agencies."

The very great importance of Federal assistance in the development of local public health units has been stressed during hearings on bills for local health units. There are many phases of preventive medicine which should form an integral part of the physician's practice. Early diagonsis and prompt, adequate treatment of disease followed by suitable rehabilitative measures are quite obviously preventive in nature.

H. R. 4312 and H. R. 4313 do take into account the importance of providing preventive services, but the mechanism by which this might be accomplished is not spelled out in detail. Unless some special provision is made, plans involving fee-for-service payment methods, permitted under these bills, are likely to result in a minimum of preventive services.

ADMINISTRATION BY A SINGLE RESPONSIBLE AGENCY

The association believes that:

"A single responsible agency is a fundamental requisite to effective administration at all levels—Federal, State, and local. The public health agencies—Federal, State, and local—should carry major responsibilities in administering the health services of the future. Because of administrative experience, and the accustomed responsibility for a public trust, they are uniquely fitted among public agencies to assume larger responsibilites and to discharge their duties to the public with integrity and skill."

It is not implied that under no circumstances should a Government health program be administered by some agency other than the legally constituted health agency at all levels. However, opportunities for much needed coordination will be administratively simplified if all governmental programs in which health is the major item are administered by the health agency.

Federal level

H. R. 4312 and H. R. 4313 provide for a National Health Insurance Board to administer title VII with the Surgeon General ad the Commissioner for social security as members. It would be preferable for the administration of health services under these bills to be placed in the Public Health Service which is responsible for preventive and other curative health services. The Public Health Service has a long record of effective administration of health programs and is ideally fitted to achieve close coordination of preventive and curative services.

State level

A single administrative agency at the State level is probably of even greater importance than in the Federal government.

H. R. 4312 and H. R. 4313 provide for States to decide whether local administration shall be carried on by an administrative officer or by a committee with an executive officer. The advisability of thus permitting administrative committees is highly questionable. Appointment of the local administrator or committee would be by the State agency. No provision is made for local participation in these appointments, so that administrative responsibility would be entirely in the hands of the State.

LOCAL ADMINISTRATIVE AREAS

Members of the public will receive all services under any of these proposed measures in some local area, usually their place of residence. Therefore, it is of paramount importance to define these local areas with the greatest care so that all types of health service may be provided with the utmost efficiency and coordination. At present, hospital areas are designated in each State under the provisions of the Hospital Survey and Construction Act, with more or less attention to the promotion of a regional type of hospital organization. Each State has, in addition, local public-health areas usually laid out in accordance with local government boundaries. Frequently, there are additional and different districts for mental hospitals, tuberculosis hospitals, school health services, etc.

Regions established to administer medical-care programs must take account of natural areas of trade and medical service. If proper regional organization of hospital and health-center services is to be accomplished as is most desirable, these regions must be relatively large in area and population.

Currently, public-health services are provided for smaller population groups, the minimum for efficient and economical administration being about 50,000. As public-health programs for chronic disease become more effective, close working relationships with hospitals will be more and more important.

To provide for needed coordination between medical-care and public-health services, the administrative areas for each service must be planned to take account of the other. Federal legislation should take cognizance of this fact. In preparing their plans, States should be required to integrate medical care administrative areas with local public-health jurisdictions. It would doubtless be desirable to include a number of local public-health areas within a single medical-care region, but no single local public-health area should be divided so that its parts would be included in more than one region.

H. R. 4312 and H. R. 4313 fail to mention the establishment of local administrative areas.

ADMINISTRATIVE PERSONNEL

The success or failure of any of the plans under discussion will hinge to a considerable degree upon the availability of sufficient numbers of trained and experienced administrators of various kinds. The present supply is much too short to provide a number adequate for rapid expansion of existing programs. As a matter of fact, this shortage may prove one of the most important limiting factors in determining the rapidity with which broad new plans can be put into efficient operation. Grants to institutions providing this type of training, now available in a number of schools of public health, and fellowships for students are essential. It is also important that accompanying the training program there be such a pace of expansion of services as will provide suitable employment for trainees. In order to make this part quite clear it is suggested that H. R. 4312 and H. R. 4313, title I, section 372 (a) (4) be amended to read, "to each school of public health which provides training leading to a graduate degree in fields relating to public health (including the administration of hospitals, clinics, and service programs)."

DETERMINATION OF ELIGIBILITY

The determination of eligibility for health service benefits is a costly administrative procedure when it must be applied on an individual basis, requiring considerable personnel and frequently leading to embarrassment of applicants for benefits. When eligibility is universal, or when it can be determined by some very simple procedure such as the demonstration of membership in an insurance program, there is essentially no problem or cost involved.

Eligibility for benefits under H. R. 4312 and H. R. 4313 would be tied in intimately with the existing social-security machinery and therefore a determination would be a very simple and exceedingly inexpensive process.

MERIT SYSTEM

It is important that suitable provision for merit systems for State administrative personnel be made, as included in H. R. 4312 and H. R. 4313.

GROUP PRACTICE

There is quite general agreement that the group practice system holds great promise of providing high quality of service at reasonable cost. H. R. 4312 and

H. R. 4313 make provision for assistance in the establishment of new groups. There is recognition under this bill of the need for Federal funds to assist in the construction of group-practice facilities for cooperatives or other nonprofit associations. This is a principal bottleneck at the present time, limiting the extension of group practice. These bills also provide that payments for services may be made to groups of practitioners as well as to individual practitioners.

Recognition of group practice in prepayment plans and a certain amount of technical and financial assistance by government in the establishment of group practice facilities is justified.

EDUCATION AND TRAINING OF PERSONNEL FOR DIRECT SERVICE

There is little doubt that Federal financial assistance will be required to train personnel necessary in the national health program. Funds are needed to maintain existing instruction and to expand the instruction to larger groups of students. We shall not attempt to discuss the exact amount of Federal assistance which will be needed by the various types of schools. Unquestionably some degree of emergency assistance will be required even if it should be determined that a survey is needed to establish the financial needs of individual schools. The association is strongly in favor of Federal assistance to educational institutions and in the development of fellowships. There should be full recognition of the high costs of public health education in relationship to some of the other kinds of training programs. Public-health training usually involves a concentrated and highly individualized course, given within a single year to rather mature people who usually have family responsibilities and, therefore, require larger stipends to maintain themselves.

The principle of providing one sum as a subsidy for each student enrolled up to the average past enrollment and a larger sum for each student in excess of past enrollment is sound, we believe. In spite of what might appear at first sight to be generous provisions of H. R. 4312 and H. R. 4313 for the several categories of health personnel, it is our considered opinion that sums in excess of these amounts will be necessary to assure the success of the project. This opinion comes out of systematic reviews of courses which have been made by the association in connection with accreditation for graduate degrees in public health.

We are of the opinion that appropriations for grants for construction and equipment in these educational institutions are sound in principle. We are persuaded that the number of those trained will not be substantially increased without funds for such a building program. Whether or not the universities will be able to match these Federal funds remains to be seen.

The National Council on Education for Health Professions seems soundly planned. Schools of public health and engineering schools operate on a regional and national basis and it is completely unrealistic to regard them as State or local institutions. The training they conduct is for public service and tax support is therefore entirely logical.

There is also need for the support of field training areas for public-health personnel. This need is entirely comparable to the necessity of hospitals for training physicians, and is equally worthy of support.

PRACTICAL NURSE TRAINING

H. R. 4312 and H. R. 4313 take account of the need for assistance in training practical nurses. This is a most important field requiring prompt development if we are to be able to staff our clinics, hospitals, and related institutions.

The association regards it as regrettable that practical nurse training is placed under the Commissioner of Education of the Federal Security Administration, thus depriving the plan of the supervision available from the professional nursing staff of the United States Public Health Service.

It seems to us an unfortunate limitation that States can secure the benefits for practical nurse training only for schools under public supervision or control. Just as in the case of professional nursing courses, some of the very best training is available under private supervision and control, and it does not seem that in the case of practical nursing these institutions should be excluded from necessary assistance.

In the United States at the present time there are only about 70 schools of practical nursing approved by any authority, and these include a considerable number under private auspices. Most of these 70 institutions are not running to capacity. In spite of the importance of the training of more practical nurses, it seems unlikely that a sum approaching $15,000,000 could wisely be used, especially if the beneficiaries are to be limited to institutions under public supervision or control. There is a sharp lack of adequately trained personnel to man the existing schools. There is, of course, a limit implied through the matching clause, page 37, lines 15–24.

The association approves the provisions for studies in this field which are badly needed and the advisory committee appears to be well set up.

The association supports in principle the idea of Federal assistance to practical nursing. The objections to this section are minor in nature and less important than the principle of Federal aid.

MEDICAL RESEARCH

The need for and importance of medical and public health research is recognized without question by the American Public Health Association, and strong support for this purpose is urged both of the conventional type of medical research and, very importantly, of administrative research as well.

It would appear doubtful in the judgment of the association whether separate institutes to conduct and support scientific research and professional training in several diseases would represent the best steps to be taken. This would permit pressures to be brought to bear on the Surgeon General in such a way that it would be difficult for him to be entirely objective about needed new institutes. The indefinite increase of national advisory councils would appear questionable in view of the established sectional committees under the research grants division of the national institutes of health. The National Advisory Council is now well set up and is capably performing an over-all function with reference to medical and public health research.

COMMENTS ON H. R. 4918 AND IDENTICAL COMPANION BILLS

The association has noted with interest the novel features of H. R. 4918, especially the scaling of subscription charges to the subscribers incomes rather than flat-rate premiums. We note also the unique idea of the "yardstick" of services.

The association recognizes the sincerity of the sponsors in their effort to preserve voluntary aspects of the insurance plans and their socially minded concern with the needs of those at lower income levels.

Among the excellent features of this bill are the encouragement to group medical practice and the recognition of the paramount public interest in the controlling boards.

Nevertheless, and in spite of some good features, the association finds itself unable to endorse this bill, believing that it is unworkable for a number of reasons, among which the following may be mentioned:

1. The plan appears to be biased toward the lower income levels where medical needs are greatest. The plan would face the disadvantage of working with a fraction of the whole population for whom no precise estimates of services can be made.
2. There is a serious question of public policy in our minds whether the administration of such large public funds can properly be committed to a nonpublic agency without clear guaranties of service to the recipient.
3. The limited Federal subsidy and the limited individual contribution leaves the States with an undertermined and open-end responsibility to make up the difference. This, we believe, would result in a much heavier load on the States that the sponsors anticipate.
4. Surely physicians and hospitals deserve some representation on health councils as providers of service, though they ought to be in the minority.
5. The provisions relating to assistance to medical education and nursing should certainly be broadened to include the public health field as well as engineering fields where the shortage of personnel is even more acute than in medicine and nursing.

CONCLUSION

May I express again my appreciation, and that of the American Public Health Association for the opportunity of appearing before this committee. It is quite apparent that I have omitted discussion of many phases of the bills under consideration. However, our association is vitally concerned with administrative problems, and we believe their importance should be stressed, which may not be done in any other testimony. If these problems are not wisely solved, it is unlikely that any of the plans being discussed will provide the high standard of services we all want.

The association is publishing this month in the American Journal of Public Health an extraordinary document on the Quality of Medical Care in a National Health Program. This concerns methods which are applicable to any and all plans for medical care however financed.

We shall be happy to provide copies of this report for the information of the committee.

STATEMENT OF THE POSITION OF THE AMERICAN PHARMACEUTICAL ASSOCIATION WITH RESPECT TO COMPULSORY NATIONAL HEALTH INSURANCE

The issues involved in determining the best means for providing adequate medical care to all segments of the population are sufficiently urgent as to require all medical care professions to make their position clear. The American Pharmaceutical Association does so herewith.

It is recognized that public interest in this subject is becoming more intensified day by day. Much information, both true and false, is being publicly disseminated with the result that there is need for clarifying the issues insofar as this is possible.

Not only should the issues be clarified but they should be rationalized in terms of traditional American principles. Compulsory national health insurance should be examined in the light of what compulsion in this field has accomplished abroad and also in the light of the changes which it might conceivably bring about in our democratic principles.

If, as it is so strongly contended by some, compulsory national health insurance would bring about the socialization of medicine, it would seem totally unsuited for solving our problems of medical care.

Once this socialization program is adopted and enacted into law it might well be the opening wedge for related movements which might seek the socialization of broad areas of industrial and professional activity.

Ours is not a socialistic country and there would seem little justification for resorting to untried socialistic experiments for meeting health needs of our people.

There is, of course, no proof that such would be the consequence of compulsory national health insurance. On the other hand it should be pointed out that this means for providing medical care has been largely confined to socialistic countries where it gave rise to or became a part of broad socialistic movements.

It must be admitted, too, that there are basic defects in the prevailing system of medical care. There are certain segments of the population and certain sections of the country for which adequate medical care is not available. This deplorable fact is due in large degree to a low economic status and to conditions which are not conducive to good medical care.

There are, perhaps, millions of our people who cannot, of their own resources, provide for themselves anything approaching adequate medical care. There are some parts of the country which are so devoid of satisfactory hospital and clinical facilities as to be highly unattractive to medical men who are accustomed to relying upon scientific diagnostic laboratories such as the modern hospital provides.

Obviously these two situations, not to mention others, constitute a challenge which must be met. Such conditions are utterly inconsistent with enlightened conceps of social and professional responsibility. These defects must be corrected as a matter of common justice and common decency. The question is as to the best method to pursue.

The American Pharmaceutical Association is of the opinion that competent surveys should be made of medical care conditions in each State and a workable program devised on the basis of the factual need. Such a survey would seem to be necessary as obviously conditions vary from State to State and between sections of the same State.

Until the facts are established it would seem foolhardy to adopt a national health-care program based upon sheer generalities when specific programs suited to specific needs are so urgently required.

The American Pharmaceutical Association is opposed to compulsory national health insurance on several grounds:

Among these are its dubious value when seen against the background of American democratic processes; the apprehension that it would lower standards of medical care and probably make it still more difficult to obtain; the fear that it would impair medical education and stifle medical research; a conviction that it would politicalize medical services thus demoralizing the field; a certainty that the costs would be fantastically high, with no one knowing what might be the ultimate tax burden upon the public.

The American Pharmaceutical Association is also of the opinion that compulsory national health insurance, while applicable at the outset to the medical profession only, would in due course socialize or nationalize pharmacy, the drug industry and all cognate branches of medical care. The costs of all phases of medical care would, in time, have to conform to the financial exigencies of the insurance program. Certain restrictions, many of them undesirable, would inevitably be placed upon the scope and nature of medical services if the costs were not to rise to confiscatory levels.

The American Pharmaceutical Association holds to the conviction that voluntary health-insurance programs should be encouraged by the Federal Government and the public and should be expended and amplified as rapidly as possible. These voluntary programs should be examined to determine their flexibility and also to ascertain how fully they do, or can meet the over-all health needs of the insured.

If these voluntary plans do not supply adequate coverage at a cost within the reach of those most in need of it, they should be revised so as to provide this coverage at this cost. Partial coverage at high cost cannot meet the requirements for adequate medical care. This phase of the subject should be inquired into promptly and proper steps taken to correct whatever defects may be found.

The American Pharmaceutical Association is also of the opinion that once health conditions and medical facilities in each State have been competently surveyed and evaluated medical-care programs should be devised to meet the needs specifically shown.

It may well be that governmental participation would be required to provide hospital and diagnostic facilities and to aid in securing physicians and other health-care professions to participate in those areas now so much in lack of them.

The nature of this participation should be carefully studied so as to assure its being consistent with sound medical administration.

It may be, too, that surveys are required to ascertain the number of medically indigent in all portions of the United States. Once the facts are in hand, some plan should be worked out with governmental support and cooperation for providing the medically indigent with adequate medical care.

This should be done not on a charitable basis, but as a matter of right. This country should be intelligent enough and resourceful enough to see to it that adequate medical care is denied none.

In this phase of the subject, however, the Federal Government should supplement activities of the medical, pharmaceutical, and other health professions rather than attempt to supplant them. Medical care is basically and essentially a medical problem. It can only be solved with the active support and understanding cooperation of the health professions.

It is the conviction of the American Pharmaceutical Association that greater progress would be made toward the solution of national health problems if they were regarded less from the standpoint of their political significance and more as truly medical matters.

The American Pharmaceutical Association holds the view that compulsory national health insurance would retard rather than advance fundamentally sound contributions to medical care. It is too inconclusive, too unsuited to the American way of doing things to be relied upon in correcting the defects in medical care. Whatever plan is adopted must be consistent with the professional ideals and objectives of medicine and in harmonious accord with those social and political concepts to which this country owes its progress and its greatness.

This is not the time to encourage socialistic experiments either in medical care or in any other phases of our national life. This is not the time to centralize in Washington control over the medical profession, medical education, and medical research. Rather, every attempt governmental and otherwise should be directed at strengthening medical care within the limits of free enterprise. Once personal initiative is stifled or emasculated it can no longer be depended upon to give the American people those high standards of medical services to which they have long been accustomed.

While the American Pharmaceutical Association is opposed to any attempt to socialize or nationalize the field of medical care, such as would be the likely effect of the adoption of compulsory national health insurance, it recognizes the urgent need of providing adequate medical care to all within the framework of free enterprise medicine.

The realization of this objective is so basic to the perpetuation of American constitutional principles as to command the cooperation of medicine, pharmacy, the drug industry, and all other professional and businessmen who are devoted to the traditions which have given us the highest standard of living anywhere in the world.

(Adopted April 27, 1949, by the house of delegates of the American Pharmaceutical Association.)

Mr. Sadowski. The committee will stand in recess until 10 o'clock tomorrow morning, at which time we will continue our hearings on title I of the bill.

(Whereupon, at 12:50 p. m., the committee recessed until 10 a. m. of the following day.)

#2502

NATIONAL HEALTH PLAN

THURSDAY, JUNE 9, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Bills considered: H. R. 4312, by Mr. Dingell, and H. R. 4313, by Mr. Biemiller (identical bills)—National health, with respect to title I, Education of Health Personnel.

H. R. 4918, by Mr. Herter; H. R. 4919, by Mr. Javits; H. R. 4920, by Mr. Case of New Jersey; H. R. 4921, by Mr. Nixon; H. R. 4922, by Mr. Morton; H. R. 4923, by Mr. Fulton; H. R. 4924, by Mr. Hale; and H. R. 5087, by Mr. Auchincloss (identical bills)—To facilitate the broader distribution of health services, to increase the quantity and improve the quality of health services and facilities, and for other purposes.

H. R. 3894, by Mr. Biemiller—To amend the Public Health Service Act to provide grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions, and for other purposes.

Mr. Priest. The committee will come to order.

In pursuance of the program announced some time ago, after having completed general statements on the over-all bills, H. R. 4312 and H. R. 4313, the committee this morning is hearing testimony on title I of the two bills mentioned and also on H. R. 3894, a bill introduced by Mr. Biemiller; a separate bill which substantially is the same as title I of H. R. 4312 and H. R. 4313.

The Chair would like to announce at this time that it is hoped by the committee that we can finish the testimony on title I tomorrow. That does not mean that that is an arbitrary decision and that anybody will be shut off if they have helpful testimony, but it is our hope we can finish the testimony on title I tomorrow and proceed with other titles and related bills.

Without objection, we will insert at this point reports from the Department of Labor, the Department of Justice, the Federal Security Agency, the Veterans' Administration, and the Comptroller General of the United States.

(The reports are as follows:)

Department of Labor,
Washington, June 9, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

Dear Congressman Crosser: Reference is made to notice received from Elton J. Layton, clerk of your committee, concerning public hearings to be held on title I of H. R. 4312 and 4313, identical national health bills, and on H. R. 3894, amending the Public Health Service Act to provide grants and scholarships, on Thursday, June 9, 1949.

My views with respect to the merits of this legislation were set forth in my statement to the committee on H. R. 4312 and H. R. 4313. I would like to have this statement considered as an expression of my comments on title I of these bills and on H. R. 3894.

Yours very truly,

MAURICE J. TOBIN,
Secretary of Labor.

DEPARTMENT OF JUSTICE,
Washington, June 7, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

MY DEAR MR. CHAIRMAN: This is in response to your request for the views of the Department of Justice concerning the bill (H. R. 3894) to amend the Public Health Service Act to provide grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions, and for other purposes.

The bill would amend title III of the Public Health Service Act, as amended (42 U. S. C., ch. 6A, subch. II), by adding thereto provisions designed to alleviate the shortages in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions. Principally, it would provide subsidies to schools (on a basis which would encourage the increase of enrollments in the mentioned fields), grants for construction and equipment to assist in the establishment of new schools and improvement and expansion of existing facilities necessary to carry out the purposes of the bill, and funds for scholarships to persons pursuing studies in the mentioned fields.

The bill would carry out one of the recommendations made by the President in his message to the Congress of April 22, 1949, which outlined the need for a comprehensive national health program.

The Department of Justice favors the purpose sought to be accomplished by this measure. The bill does not, however, relate to a matter within the purview of this Department and, accordingly, it is unable to advise as to the particular provisions contained therein.

The Director of the Bureau of the Budget has advised that there is no objection to the submission of this report.

Yours sincerely,

PEYTON FORD,
The Assistant to the Attorney General.

FEDERAL SECURITY AGENCY,
Washington, June 8, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This is in response to your letter of March 31, requesting a report on H. R. 3894, a bill to amend the Public Health Service Act to provide grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions, and for other purposes.

On May 19, 1949, we submitted to your committee our report on H. R. 4313, also introduced by Mr. Biemiller, title I of which contains provisions very similar to those of the instant bill. While it is likely that the later bill was intended to supersede the instant bill, we are taking the occasion of your request for a report on H. R. 3894 to set forth more fully than was possible in our May 19 report an analysis of the provisions of this important proposal, and our reasons for believing it to be one of the most timely and desirable legislative proposals in the field of health under consideration by this Congress.

SECTIONS 1 AND 2 OF THE BILL

The first section of H. R. 3894 would amend the Public Health Service Act by adding a new part H to title III of the act providing for grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions. Specifically, this part of the bill would authorize appropriations for:

1. Payments to schools of medicine, dentistry, dental hygiene, nursing, public health, and sanitary engineering to meet the costs of (*a*) establishing, maintaining, and enlarging their staffs, and (*b*) maintaining and operating their facilities, including the acquisition of equipment, in such sums as may be necessary to make the payments for the fiscal year 1950 and for each fiscal year thereafter.

2. Grants for construction and equipment to assist in the establishment of new schools and improvement and expansion of existing facilities, including teaching hospitals and other related facilities and equipment, necessary to carry out the purposes of the act, in such sums as may be necessary from time to time to carry out the purposes of the act.

3. Payments to the States to cover the costs of State scholarships in medicine, dentistry, dental hygiene, nursing, public health, and sanitary engineering, in order further to increase the number of persons adequately trained; $50,000,000 for the fiscal year 1950, $60,000,000 for the fiscal year 1951, and thereafter such sums as the Congress may determine to be necessary to cover the costs of the State scholarships awarded.

In the first section of the new part H, Congress would find and declare that: (1) There is a shortage of physicians, dentists, dental hygienists, nurses, sanitary engineers, and other health personnel essential to maintaining and improving the Nation's health, and this shortage is likely to increase unless facilities and opportunities for training such personnel are strengthened and expanded; (2) the cost of providing adequate training and facilities in these fields is so high and the sources of income for the schools are so limited as to make it impossible for the schools to operate at present capacity on a sound financial basis, discouraging the expansion of existing schools or the construction and equipment of new schools; and (3) it is, therefore, the policy of the United States to assist in providing opportunities for more qualified individuals to obtain training in the medical, nursing, dental, dental hygiene, sanitary engineering, and public health professions.

The Federal administration of these three appropriations would be a responsibility of the Surgeon General of the Public Health Service.

Section 2 of the bill provides for a National Council on Education for Health Professions to consist of four stated ex officio members and 20 members appointed by the Surgeon General with the approval of the Federal Security Administrator without regard to the civil-service laws. The appointed members would serve for 4-year staggered terms and they would not be eligible for reappointment until a year had elapsed since the end of their respective preceding terms. Provision is also made for special advisory and technical committees in the various professional fields.

The principal features of the three aspects of the program contemplated by the first and second sections of the bill, that is, the new part H of title III of the Public Health Service Act, may be outlined as follows:

1. *Payments to schools for costs of instruction.*—Payments to schools for costs of instruction for the fiscal year 1950 and for each of the two succeeding fiscal years would be based in (*a*) the average number of students enrolled therein for the three fiscal years ending June 30, 1949, the amounts per student being $300 in medicine, $250 in dentistry, $150 in dental hygiene, $200 in nursing in curricula leading to degree in nursing, $350 in public health, and $200 in sanitary engineering, and (*b*) on the number of students in excess of the average enrollment, the amount per student varying from $1,200 in sanitary engineering to $2,400 in public health. For nursing schools providing basic training leading to a diploma as a professional nurse, the payments would be $200 for each student in the first year of training, $150 for each student in the second year, and $50 for each student enrolled in the third year, conditioned upon waiver of present tuition and fee charges, and charges for food and lodging.

The total payment to any school, other than a school of nursing which provides basic training leading to a diploma as a professional nurse, for any fiscal year may not exceed 50 percent of the amount which the Surgeon General determines to be the cost of instruction in that school for the year. A school would be eligible for payments if it is a public or nonprofit institution within the continental United States exempt from Federal income taxation, and if it is approved or accredited by a body or bodies approved by the Surgeon General after consultation with the National Council on Education for Health Professions.

Two conditions for the grants would be: (*a*) assurance that the school will not impose unreasonable restrictions against the admission of out-of-State students, and (*b*) that the school will submit reports and comply with conditions prescribed in regulations.

The measure would require the Surgeon General to report to the Congress not later than January 1, 1952, his findings based on surveys and studies which he would be authorized to make, together with appropriate recommendations for needed adjustments in the amounts to be paid to the schools.

2. *Grants for construction and equipment.*—The Surgeon General, after consultation with the National Council on Education for Health Professions, would be authorized to make grants to the schools for construction and equipment. Such a grant could not exceed 50 percent at the cost of the construction and equipment with respect to which it is made (except under certain circumstances involving grants for hospitals). Application for such grants would have to be made prior to July 1, 1955. A grant could not be made to a school unless (1) it gave assurance that, upon completion of the construction and equipment and for 10 years thereafter, it would be operated as a public or nonprofit institution, (2) it would be approved or accredited, and (3) it would not impose unreasonable restrictions upon the admission of out-of-State students.

Other features of the bill which apply to both of the preceding appropriations are: (1) Nondiscrimination in the admission of students on the basis of race, creed, color, or national origin, and (2) provision for withholding and the recapture of payments under certain conditions.

3. *Payments to the States for State scholarships.*—The total number of scholarships in each field for each year would be determined by the Surgeon General in accordance with regulations designed to assure that the scholarship program would keep pace with the progress made in financing the costs of instruction and facilities. The moneys would be apportioned to the States on a population basis, but no State would be apportioned fewer than two scholarships. To secure the benefits of the scholarship appropriations a State would be required, through its legislative authority, to accept the provisions of the Federal legislation and provide for the administration of the funds. The State would have to establish or designate a single State agency to prepare or carry out, or supervise the carrying out of, a State plan. Under certain circumstances the chief executive of a State could accept the provisions of the act and designate or create a State agency to carry out the scholarship provisions. The State plans would be examined by the Surgeon General and would be approved by him if, after consultation with the National Council on Education for Health Professions, he found that they conform to the law. Not to exceed 1½ percent of the scholarship funds apportioned to a State would be used for State administration.

Specifications are made as to what the State scholarship plans must include. The scholarships would provide (1) the cost of tuition, educational fees, books, and equipment, and (2) to the extend the Surgeon General finds necessary, monthly maintenance stipends not to exceed $125 a month for a student without dependents and $175 a month for a student with two or more dependents. The bill contains numerous details concerning the scholarships.

SECTIONS 3 TO 12 OF THE BILL

Part B of the bill, consisting of sections 3 through 12, sets forth plans and requirements for the training of practical nurses, and authorizes appropriations of $15,000,000 annually for this purpose. This section would be administered by the Commissioner of Education, through State boards for vocational education.

In general, the provisions of this part correspond to analogous provisions in the Smith-Hughes Vocational Education Act (39 Stat. 929), covering training in agriculture, home economics, and trades and industry. Thus, this bill would in effect, provide an additional category of vocational training, i. e., practical nurse training.

Each State will be required to match by State or local funds or both (*a*) 25 percent of the amount expended in the 2-year period ending June 30, 1956; (*b*) 50 percent for the 2-year period ending June 30, 1958; and (*c*) 100 percent for any fiscal year thereafter.

Of the Federal funds appropriated annually, 50 percent shall be allotted among States having approved State plans on a population ratio, and the remaining 50 percent among States, with approved plans, which can make the most efficient use of such funds.

The Commissioner could, with the approval of the Administrator, appoint such advisory committees on practical nurse training as he deems necessary.

THE NEED FOR FEDERAL AID

Medical manpower is an indispensable resource for the Nation's health. Medical care and public health cannot advance unless well-trained individuals are available in sufficient numbers to render adequate health care to the population. The high and increasing cost of professional education to institutions and to students today jeopardizes the production of the needed personnel.

The President's Commission on Higher Education found broad areas of inadequacy in the supply of health personnel. The commission reported:

"Shortages of professional personnel to take care of the health needs of the Nation must be of serious concern to institutions of higher education. The commission recognizes the high cost of medical, dental, nursing and pharmaceutical education, but the cost of institutional service, as a result of lack of health care, is even greater for the Nation. It is estimated that this amounts to $500,000,000 a year."

The commission concluded its report with the recommendation that the expansion of physical facilities and their maximum use in the professional health fields should not be delayed.

The findings of the commission emphasize the many claims made in recent years that means must be devised as soon as possible to stabilize the financial condition of health and medical training institutions, to expand training facilities to accommodate more students, and to provide financial assistance to students preparing for the health profession.

Within the last year, the Association of American Medical Colleges pointed out that "the quality of medical education is in danger of deteriorating just when demands for medical care are unprecedented and steadily rising." It described the "underfinancing of medical schools as a problem of national moment" because "the medical welfare of our people depends upon the production of adequate numbers of well-trained physicians and research workers." It went on record as recognizing that public support is vital.

Support of professional health training institutions in this country today comes from four sources—private endowments, private gifts, tuition fees, and taxes. Well over half the 4-year medical schools are maintained principally through endowments, gifts, and tuition fees. While the remaining schools are primarily supported by State or city revenue, they also must depend upon private sources for important parts of their programs.

Incomes from endowments and gifts have remained fixed or are decreasing; at the same time, rapid advances in the health and medical sciences have added tremendously to the cost of medical education. This fact is demonstrated by comparison of present medical school financing with that of 40 years ago. The average medical school in 1910 looked to tuition fees for about 70 percent of all its expenses. The balance was supplied from endowments and public funds. While tuition costs have mounted steadily since that time, and a notable rise has taken place in public funds appropriated, these have in no way kept pace with the great increase that has occurred in the costs of medical education. The medical school in recent years has come to depend more and more upon outside sources of revenue for the major part of its expenditures. The same is true of schools of dentistry and public health.

The financial instability of professional health training institutions is a serious obstacle to the expansion of existing schools and to the establishment of new schools where needed. At the same time, shortages of professional personnel exist in all health fields. In many areas of the country, these shortages are acute.

Conservative estimates, based on present and anticipated demands and on the present rates of output, retirement and death, indicate a shortage of 15,000 to 30,000 physicians by 1960. If a yardstick based on adequacy rather than merely on anticipated demand for physicians' services is assumed, the figures are even larger. For example, if standards for the country as a whole were raised to the present level of the 12 States with the highest ratio of phyisicians to population, the estimated deficit would be from 35,000 to 50,00 physicians by 1960, depending on the population of the country at that time. As now situated, many medical schools can do little to expand enrollments. In fact, a substantial number of medical schools need assistance even to maintain minimum standards of instruction with present enrollments. Practically all schools require aid if facilities are to be expanded.

The most conservative figures, place the current need for dentists at around 100,000. This estimate is based on the use of dental hygienists for all prophylaxes. At present, there are approximately 80,000 dentists. The production of dental hygienists averages only around 440 a year. These are presently trained in 13 schools. Of the 41 dental schools 11 provide training for dental hygienists. It is obvious that the training of an adequate supply of dentists and of dental hygienists will involve an expansion of dental schools on a scale that can be accomplished only over the years. The schools are unable to achieve any expansion without greater financial support. Indeed, there is some question whether, without additional help, dental schools will be able to maintain even the present inadequate rate of output.

Nursing represents the largest single group of professional health workers in the country. A conservative estimate of the current nurse shortage has been set at 40,000. Surveys have indicated that up to 200,000 additional nurses will be needed by 1960 to take care of an increasing population and to take advantage of new knowledge in patient care and public health. Yet admissions to schools of nursing have dropped 40 percent from the wartime peak of 67,000 when the Federal Government was subsidizing nursing education. The 43,000 freshmen who entered schools of nursing in 1948 will produce 28,000 graduates, or only about 6,000 more than are annually leaving the profession.

Federal assistance is particularly necessary to schools providing training leading to a degree in nursing since it is these schools which supply the instructional, supervisory, and administrative staff which is essential for the training of large numbers of nurses. Schools provding basic professional nurse training leading to a diploma likewise need assistance to strengthen staffs so that the quality of training may be improved.

Provision for the training of practical nurses is equally important. Trained practical nurses would be expected to serve as members of nursing teams; as such they could render a large proportion of the nursing service needed by patients who are chronically ill, or who are convalescing. Also, under the direction of the professional nurse they would carry out certain procedures in the care of acutely ill patients. In public health nursing, practical nurses can give bedside care to patients, particularly patients who are chronically ill in homes. They can also assist the professional nurse in the clinincs operated by public health agencies.

Nonprofessional nurse personnel, for the most part untrained, now give a substantial portion of the nursing care of hospital patients. Needs in homes are also great. There are now approximately 85,000 nontrained practical nurses caring for the sick in this country. Only a relatively small number of practical nurses receive training under existing vocational legislation which is administered under the trade and industry regulations of the various States.

Sanitary engineering is a field of rapidly increasing importance to public health. At present, three engineering schools in the country have accredited curricula in sanitary engineering, and 27 offer options in sanitary engineering as part of accredited curricula in civil engineering. The annual number of graduates in sanitary engineering over the past 10 years has averaged about 50. At the end of 1947, about 800 sanitary engineers were employed by State and local health departments. On the basis of one sanitary engineer per 60,000 population, there should be about 2,300 sanitary engineers in State and local agencies; this need will increase with the development of public health services. A canvass of only 10 States revealed 81 position vacancies for sanitary engineers in State or local health departments. It is clear that demands for engineers in health agencies are growing at a faster rate than the present schools are supplying trained personnel.

Shortages of trained public health personnel constitutes a major drawback to the advancement of public health practice. Only a small part of the population is served today with adequate public health services and personnel—physicians, dentists, nurses, sanitary engineers and others. Legislation designed to provide Federal asistance for the development of local health units with full-time staffs serving all communities is now under consideration. If favorable action is taken on this legislation the need for increasing the numbers of students in our schools of public health will be even greater, for it is upon these schools that we depend for the specialized public health training for doctors, engineers, nurses, and others who constitute the key personnel for public health units

COMMENT ON PROVISIONS OF H. R. 3894

Generally speaking, we believe that the provisions of H. R. 3894 are well designed to meet the immediate need for assistance to schools training professional health personnel. There are several points, however, where we believe some modification would be desirable. Furthermore, we would like to call attention to a number of other points where we believe it highly essential that there be a clear understanding of the objectives and approach embodied in the provisions of this bill.

We are gratified to note that the bill recognizes the fact that our health personnel shortages are not confined to physicians and dentists, but include a number of other categories as well. Just where to draw the line is a problem in which there are differences of opinion, but we believe the categories enumerated in H. R. 3894 are those most in need of immediate action.

The provisions of the bill relating to grants to schools to assist in meeting costs of instruction are particularly deserving of comment, for it is on this facet of the problem that a clear understanding of objectives and approaches is most needed. For purposes of this report we will illustrate our comments by particular reference to the problem of medical schools, but they are applicable, with some modifications to other categories of schools covered by the bill.

The principal objective of these provisions is to overcome the shortages of physicians by increasing the output of our medical schools. With this objective we are in complete accord. As pointed out earlier in this report, however, the financial condition of our medical schools is so precarious that we cannot confine our attention to Federal assistance for expansion only. Schools which are incurring larger and larger operating deficits are in no position financially to expand their enrollments unless and until they can meet the costs of education for their present student bodies. We are, therefore, in agreement with the principle, embodied in H. R. 3894, that some Federal assistance should be provided to assist schools in overcoming their present operating costs as well as to subsidize their expansion.

It is easier, however, to define the principle than to translate it into terms of a precise formula. In the first place, there is a wide range in the costs—and also in the operating deficits—among our 77 medical schools. A uniform basis for distributing funds is therefore difficult to apply with equity. This would suggest a flexible allocation formula based in some manner on the operating costs of the several schools. At the present time, however, this alternative is not feasible because of the almost complete lack of standard cost accounting practice among the different schools. The best immediate approach, therefore, is probably that represented by H. R. 3894—namely a fixed, uniform formula to be applicable pending the findings of a thorough survey of needs, costs, and other related factors.

Considered in the light of these underlying concepts and circumstances, we believe that the amounts or rates of assistance prescribed in section 372 (b) are reasonable, although unavoidably arbitrary. For example, each school of medicine would receive $300 per student, up to its "average past enrollment," to assist in meeting its present financial difficulties. In addition, it would receive $1,700 for every student above its average past enrollment. The $300 is undoubtedly too low a figure to meet the needs of most schools on a continuing basis, but as an interim rate (until 1953) while a thoroughgoing study is being made, it should be large enough to avoid a financial break-down during the survey period.

The rate of $1,700 per student for additional students beyond the average past enrollment reflects the principle which we believe should be applied, even though it will not be equally equitable for all schools. While costs of instruction vary considerably among schools, the average for all schools is about $2,200 per student per year, while the average annual tuition is $500. Thus $1,700 represents the average net cost to the school, which must be met out of endowments or other sources of school revenue. Since these revenues are inadequate to cover the costs of present enrollments, it is apparent that only the assurance of payments equal to this full net cost will make it possible for the schools to expand their present enrollments. Here again, however, this arbitrarily fixed rate is justifiable only during the initial period, while a survey is being made to determine a more adequate basis for such payments.

For the same reasons we believe that the payment rates covering instructional costs specified for other categories of health personnel are sound in principle, even though the amounts themselves are somewhat arbitrarily selected. The only variation in formula, it should be noted, is found in the rates prescribed for payments to diploma (R. N.) schools of nursing. For this category of schools

H. R. 3894 prescribes payments of $200 each for first-year students, $150 for second-year students, and $50 for third-year students—on the condition that the school will waive all charges for room and board, tuition, books, etc. These schools of nursing, which are operated in almost all instances as adjuncts of hospitals, are not regular collegiate institutions, and their operations and financing arrangements are not comparable with those of collegiate institutions. Although the hospitals which operate the schools are in many cases having serious financial problems, the primary problem here is to induce more girls to apply for such training. In view of these circumstances, the indirect scholarship provision for such schools which is embodied in H. R. 3894 appears to be an appropriate approach. The amounts prescribed are sufficient to cover present tuition rates in virtually all schools (room and board is not provided in most cases), and payments for second-year and third-year students are in keeping with present practice in most schools. Again, we doubt that the rates will prove adequate in the long run, but they are justifiable as a first-aid measure pending a complete study of needs and costs.

The provisions of H. R. 3894 (part B) relating to the training of practical nurses meet with the general approval of this Agency. The training of practical nurses is composed of elementary theoretical instruction, combined with practice in hospitals. Practice in homes may also be desirable. Experience has demonstrated that one satisfactory method of providing such training is through vocational schools which have agreements with nearby hospitals pertaining to the necessary clinical experience arrangements. Specific appropriations for practical nurse training would encourage all States to establish such programs, and would result in a greater supply of adequately trained practical nurses in a short period of time, so that one phase of the demand for nursing care could be promptly met.

The provisions of H. R. 3894 relating to construction grants are particularly important, in our opinion, if Federal assistance is to lead to the training of increasing numbers of health personnel. In the case of medical schools, for example, most schools are now operating at very near the full capacity of their present physical plant, so that any substantial increase in enrollment will depend upon the construction of new or expanded facilities. Here again, the financial plight of most schools is such that assistance from the Federal Government appears to be essential if any substantial plan expansion is contemplated. It should be noted that H. R. 3894 properly provides that any construction of teaching hospitals with Federal funds made available pursuant to this bill is to be coordinated with specifications and procedures already established under the Hospital Survey and Construction Act of 1946.

This Agency is in accord with the principle of including some student-aid provisions in any general measure relating to the education of professional personnel. We should like, however, to clarify our understanding of the objectives of such provisions, and to suggest two amendments to the provisions of H. R. 3894.

In our opinion, scholarship or other student-aid provisions are justifiable primarily as a means of equalizing educational opportunities among students by removing the financial barrier to such education. This is of particular importance where the type of education desired is exceptionally expensive, as in the case of medical and dental schools.

Scholarship aid may also be justified in some cases as a means of recruiting applicants for such training in numbers sufficient to meet national needs, as in the case of nursing, but it should be noted that this justification is not applicable in the case of all of the professional categories covered by H. R. 3894. For example, in the case of physicians, since the number of qualified applicants is now two or three times as great as first-year admissions to our medical schools, it is apparent that additional inducements will have no effect on total enrollments for some time to come.

Another possible relationship between scholarships and personnel shortages relates to the distribution of such shortages. It has been proposed, for example, that scholarships carry with them the obligation to practice for a specified time in some shortage area. Although experience to date with such arrangements in the medical field are far from conclusive, some further experimentation might be justifiable.

Our first suggested amendment to the scholarship provisions of H. R. 3894, relates to their present applicability to students in diploma-granting schools of nursing. Inasmuch as grants to such schools are provided on the condition that the schools provide free tuition, books, and room and board for all their students, there would appear to be no need for providing any direct scholarships for such students.

Second, we believe that the conditional requirement that those receiving scholarships must agree to spend 5 years in the practice of their profession will serve no useful purpose. If some condition of practice is to be included, it might more appropriately specify the area of service or the class of employer—e. g., Federal, State, or local governments. We believe that the corresponding provisions of title I of H. R. 4312 and H. R. 4313 are preferable in this respect to the provisions in the instant bill.

We believe that the provisions of the bill should be extended in their entirety to Puerto Rico and the Virgin Islands. As presently written, section 372 (b) would apparently limit instruction and construction grants to schools in the continental United States.

We would also like to suggest to the committee at the appropriate time several technical amendments designed to improve the provisions of part B of the bill relating to practical nurse training.

Finally, I would like to make an observation concerning the relation of the specialized Federal aid program proposed in this bill to Federal aid to higher education generally. I firmly believe that the Federal Government has a definite responsibility to assist in the development of an adequate program of higher education to meet the national needs, and I believe that ideally any legislation in aid to higher education should be sufficiently comprehensive to embrace the entire field, rather than a portion of that field as do the instant proposals. Primary responsibility for the administration of such a general comprehensive program should be vested in the Office of Education of this Agency rather than split up as between the various Government agencies and units interested in particular phases of the program. I would hope that when any such comprehensive program comes up for consideration by the Congress, the Congress will appreciate the necessity for integration of the special programs proposed by H. R. 3894 as well as any other specialized programs then in effect, with the comprehensive program, both as respects content of the programs and responsibility for their administration.

Time has not permitted us to obtain advice from the Bureau of the Budget as to the relationship of this bill to the program of the President.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

VETERANS' ADMINISTRATION,
Washington, D. C., June 7, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CROSSER: Reference is made to your letter of March 31, 1949, requesting a report by the Veterans' Administration on H. R. 3894, Eighty-first Congress, "A bill to amend the Public Health Service Act to provide grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions, and for other purposes."

The general purpose of the bill is to assist in relieving the shortage of physicians, dentists, dental hygienists, nurses, sanitary engineers, and other health personnel by assisting schools which provide training in these professions in meeting their costs of instruction and by giving financial assistance for the construction and equipment of new schools and the expansion of existing schools with a view to providing opportunities for more qualified individuals to obtain such training and by providing scholarships to induce greater numbers of qualified students to train for such professions.

The bill would not be administered by the Veterans' Administration and accordingly no effort will be made in this report to analyze its detailed provisions. One provision of interest to the Veterans' Administration is that the National Council on Education for Health Professions, which would be authorized by the amendment, to the Public Health Service Act, contained in section 2 (a) of the bill, would have as an ex officio member the chief medical officer of the Veterans' Administration or his representative.

It is noted that in connection with the proposed scholarship program provided by the bill, it is specified that no scholarship will be awarded to any person for any period during which he is receiving education or training under the

Servicemen's Readjustment Act. The Servicemen's Readjustment Act program of education and training is applicable to veterans of World War II and, depending upon the length of their service, may amount to a maximum of 4 years' training. In general, the educational program under the Servicemen's Readjustment Act is limited by a final cut-off date of July 25, 1956, so that, with certain exceptions, education and training cannot be afforded under that program beyond July 25, 1956. No reference is made in this provision of the bill to disabled veterans of World War II who may be receiving rehabilitation training under Public Law 16, Seventy-eighth Congress, as amended, which type of training is likewise circumscribed by the terminal date of July 25, 1956.

The provisions of the bill do not appear to be designed to impair in any way the system of hospital benefits and medical care now administered by the Veterans' Administration in behalf of veterans.

Attention is invited to H. R. 4312, Eighty-first Congress, "A bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes," which bill is related to the recommendations of the President of the United States as contained in his message to the Congress of April 22, 1949, advocating the enactment of a comprehensive national health program. The provisions of title I, "Education of health personnel," of H. R. 4312 are similar to the provisions contained in H. R. 3894. Principal points of difference in the bills in respect to these provisions are:

H. R. 4312 would provide that the funds available for scholarships shall be apportioned among the States having State plans approved on the basis of one-half of each such sum on the basis of population and one-half of each such sum on the basis of relative need of each such State for additional personnel trained in the field for which such sum is available. H. R. 3894 would provide that the apportionment shall be made on the basis of the ratio of the population of the State to the population of all of the States.

H. R. 4312 would provide that a scholarship awarded shall be conditioned upon agreement by the appointee to serve, upon completion of his training (including internships and residencies), 1 year for each two academic years during which he received the benefits of the scholarship (1) in the rendition for the State which selected him, or for a political subdivision thereof, of service in his profession or in the practice of his profession in an area designated by the State agency as one in need of additional personnel trained in such profession, or (2) with the approval of the State agency, in the practice of his profession on full-time active duty in a medical agency or unit of the United States. H. R. 3894 would provide that such appointments would be conditioned upon agreement by the appointee to serve, upon completion of his undergraduate and graduate studies and any required internship (including residencies), 5 years in the practice of his profession with respect to which the scholarship is granted.

On May 24, 1949, a report was submitted to your committee on H. R. 4312 and H. R. 4313, identical bills. In that report, I stated that I do not conceive it as being within the compass of my authority or responsibility as Administrator of Veterans' Affairs to undertake the recommendation of any particular plan for meeting the over-all problems of the United States in the field of hospitalization and medical care. This statment was addressed to H. R. 4312 and H. R. 4313, the provisions of title I of which, however, as noted above, are similar to the provisions of H. R. 3849. No further comments, therefore, are presented concerning this proposed legislation.

Advice has been received from the Bureau of the Budget that the objectives of this legislation are in accord with the program of the President.

Sincerely yours,

O. W. CLARK
(For Carl R. Gray, Jr., Administrator.)

GENERAL ACCOUNTING OFFICE,
Washington, April 29, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

MY DEAR MR. CROSSER: Further reference is made to your letter of March 31, 1949, acknowledged by telephone April 5, requesting a report on H. R. 3894, Eighty-first Congress, entitled "A bill to amend the Public Health Service Act to provide grants and scholarships for education in the medical, dental, dental hygiene, public health, nursing, and sanitary engineering professions, and for other purposes."

A companion bill, S. 1453, was introduced in the Senate March 29, 1949.

In section 371 of the proposed amendment the policy of the United States is stated to be "* * * to take such steps and to utilize such of its resources as are necessary to provide adequate numbers of persons trained in the medical, nursing, dental, dental hygiene, sanitary engineering, and public-health professions by assisting schools which provide such training in meeting their costs of instruction and by giving financial assistance for the construction and equipment of new schools and the expansion of existing schools, with a view to providing opportunities for more qualified individuals to obtain such training regardless of their race, creed, color, or national origin."

Briefly, the bill—which is 34 pages in length—would provide for payments based on enrollment to schools of medicine, etc., which are public or nonprofit institutions exempt from Federal income taxation; authorize the Surgeon General to make grants for construction and equipment of schools for carrying out the purposes of the act; authorize payments to States for scholarships; provide for awarding scholarships to students; require the Surgeon General to provide for an annual audit of expenditures; provide for the establishment of the National Council on Education for Health Professions, consisting of the Surgeon General of the Public Health Service, the Commissioner of Education or his representative, the chief medical officer of the Veterans' Administration or his representative, a medical representative designated by the Secretary of Defense, and 20 members appointed without regard to the civil-service laws by the Surgeon General, with the approval of the Federal Security Administrator; authorize payment to members of the national councils and of special advisory and technical committees at a rate to be fixed by the Federal Security Administrator, not exceeding $50 per day, while attending conferences or meetings of their respective councils or committees or otherwise serving at the request of the Surgeon General, plus travel and subsistence expenses while so serving away from their places of residence; provide for training of practical nurses; and authorize appropriations for the purposes of the act.

This Office has no information as to the need or desirability of the proposed legislation and, therefore, I make no recommendation as to the merits of the bill H. R. 3894.

It is noted that the word "legislation" in line 20, page 16, of the bill, apparently is intended to be "legislature"; that the word "times" in line 24, page 23, should be "time"; and the word "as" apparently should be inserted immediately following the word "persons" in line 25, page 28.

Sincerely yours,

LINDSAY C. WARREN,
Comptroller General of the United States.

Mr. PRIEST. We are very happy this morning to have the Surgeon General, Dr. Leonard A. Scheele, as our first witness. You may proceed, Dr. Scheele.

STATEMENT OF DR. LEONARD A. SCHEELE, SURGEON GENERAL, UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY, WASHINGTON, D. C.

Dr. SCHEELE. Mr. Chairman and members of the committee, public interest in measures for improving the Nation's health has been sharply intensified in recent years. Both public and private agencies have proposed new or improved health programs, and the Congress has enacted a large number of health bills into law. I need only to mention the legislation creating institutes in cancer, heart, mental and dental diseases, legislation authorizing programs in tuberculosis and venereal disease, and grants to States for general health work and for hospital construction, to exemplify the leading role that the Congress has played in the promotion of the Nation's health. There is a considerable variety of further proposals pending before the committee at this time. A major obstacle to the fullest execution of most of these measures and proposals is the shortage of health personnel. In many ways the lack of sufficient numbers of qualified personnel to meet even minimum standards is the Nation's No. 1 health problem. It should have the highest priority. Naturally, therefore, we are gratified to see legislation proposed which would make a frontal attack on these shortages.

In the course of these hearings your committee will hear from organizations of educators, university presidents, and deans who are far more familiar with the details of administration of educational institutions than I am. Accordingly, I will not undertake this morning to go into details which will be discussed by the experts.

I would like simply to highlight a few of the major issues, to summarize the major problems involved, and to sketch thereby the background against which the more specific testimony may be considered. While the three principal bills before the committee are H. R. 3894, H. R. 4312, and H. R. 4313, I understand that H. R. 3894 has in effect been superseded by title I of 4313, which is identical with title I of H. R. 4312. I have also noted with much interest that still another group of identical bills—introduced only a few days ago—contain provisions relating to the education of health personnel. With your permission, I should like to make some comparative reference to these latter bills, for the purpose of clarifying certain fundamental concepts involved. In the interests of simplified reference I should like in the remainder of this statement to address my comments to title I of H. R. 4313, as representing one group of bills and H. R. 4918 as representing the other group.

I would like to remind you again that 4313 and 4312 are identical and that when I refer to H. R. 4313, I will in fact also be referring to 4312, although I will not mention it by number.

Superficially, H. R. 4313 and H. R. 4918 appear to differ substantially, but, as a matter of fact, their provisions actually represent a quite high degree of agreement. They both recognize that there are several professions which make up the health team and that there are problems in connection with the training of each. They both agree that existing information is incomplete and that a careful survey is needed to provide a basis for a continuing program. Both agree that, pending the availability of more adequate data, some immediate aid is necessary now. Both also agree that there should be not only some stimulus to expansion, but also some contribution to the operating expenses of the schools for maintaining present enrollment.

We cannot stress too much the fact that the present basis of medical and related education needs support.

The two principal differences between H. R. 4918 and title I of H. R. 4313 appear to be differences of degree rather than of philosophy. One difference is with respect to the schools which would receive immediate financial assistance. H. R. 4918 makes provision for immediate assistance to only medical and nursing schools and defers aid to any other schools, while H. R. 4313 provides immediate assistance to the several types of schools. The terms of assistance under both bills would be subject to revision after the problem had been studied adequately.

The other difference comes on the relation of grants for maintenance to those made for encouraging the expansion of medical- and nursing-school enrollments. H. R. 4918 provides $500 per student per year for existing enrollments and $1,500 per student per year for additional students, while H. R. 4313 provides $300 for present students and $1,700 for additional students. For university nursing schools, both bills provide $200 per student for existing enrollments, and $1,200 for each student above the average past enrollment. The formula for hospital schools of nursing is also the same in both bills.

Before proceeding to consider the more specific problems with which both bills deal, I should like to express our preference for H. R. 4313 because it attacks the problem more comprehensively—by providing aid for costs of instruction, for the construction of physical facilities, and for student aid—and because it affords immediate assistance to more categories of professional schools.

I have already said that the shortage of health personnel is acute. Although there may be some disagreement on the precise magnitude of the shortage of physicians for the practice of medicine and for public health work, there is no longer any real disagreement that a shortage does exist. Conservative estimates, based on present demands and on present rates of graduation, retirement, and death, indicate a shortage of at least 15,000 by 1960.

Beginning late last year the Federal Security Agency held a series of conferences with deans of medical and other training institutions for the health professions to get an appraisal of their views on what expansion was either possible or contemplated under present circumstances. It was obvious from the meetings that many medical schools can do little or nothing to expand enrollments now.

Although the total number of students in the schools of public health has increased constantly from 119 in 1930 up to 655 last year, they fall far short of the total number needed. These are the schools, you may recall, that provide postgraduate instruction for physicians, nurses, sanitary engineers, and other personnel needed for the key posts in Federal, State, and local public and voluntary health agencies. In other words, they take students with basic training in the several health disciplines and give them intensive training in the application of the health sciences to community health problems—such as the prevention and control of communicable diseases, environmental sanitation, community programs for the protection of maternal and child health, and health education of the public. To meet estimated needs, these schools must train 23,500 public health workers by 1960, or 2,350 per year. This means that it would be necessary to multiply by three or four times the present annual enrollments.

The need for dentists is only slightly less acute. The most conservative current estimates place the need for dentists at at least 95,000 by 1960. There are about 75,000 active practicing dentists in the country today and based on present rates of graduation and attrition, there will be a shortage of at least 5,000 by 1960.

One way in which we can help to relieve this critical shortage of dentists is to increase the supply of dental hygienists, whose training enables them, under proper supervision to relieve dentists of a substantial burden of routine but time-consuming procedures. There are now 13 schools training dental hygienists, 11 of which are associated with and staffed in part by the dental schools. The present annual graduation of dental hygienists averages only around 400, and without greater financial inducements to both schools and students, there is little prospect of approaching the country's need for these skilled workers.

The nation requires a greater number of nurses than of any other one type of health personnel. While the supply of nurses is increasing the demand for nursing services has far outstripped it. Total enrollments have dropped from the war peak of nearly 130,000 to less than 90,000 each year despite vigorous recruitment efforts.

I am sure you will recall the cadet nurse program and the intensive recruiting that was done during the war. That, of course, has stopped now.

Today the Nation has 280,500 professional nurseses, which is 74,000 short of currently estimated needs. The total number needed by 1960 is conservatively estimated to be more than 400,000. This estimate moreover presupposes the supporting services of at least 200,000 practical nurses who require briefer and less expensive training. Other than the shortage of total numbers of nurses the greatest need is for nurse teachers, which must be supplied if progress is to be made in increasing the total supply of nurses for hospitals, homes, and public health agencies. Many hospital wards are now closed for lack of nurses, and many patients, particularly in mental hospitals, receive little or no nursing care. Some local health services are now without nurses, and the supply of public health nurses must be substantially increased in order to meet the service standards contemplated in proposed legislation relating to local public health units now pending before this committee.

The goals for even minimum services to the public require the following annual average admissions for the next 10 years: 50,000 students for hospital schools of nursing, 8,000 students for basic training in university schools of nursing, 10,000 students for advanced study in university nursing schools, 20,000 students for practical nurse courses.

In 1948, only 43,000 students were admitted to university and hospital schools of nursing. During the war these schools admitted 65,000 students with the assistance of Federal aid. In 1948, 4,700 full time students were enrolled for advanced study. There were less than 3,000 students enrolled in practical nurse courses.

Finally, we are faced with a shortage in still another category of health personnel, namely, sanitary engineers. These especially trained personnel are an essential part of the health team in every public health jurisdiction—local health units, State health departments, and our Federal health agency. Particularly if we are to achieve our goal of adequately staffed local health units throughout the country, we must step up our production of sanitary engineers.

Of the estimated total of 2,500 in the entire country, about 800 sanitary engineers were employed in State and local health departments at the close of 1947. On the conservative basis of one sanitary engineer to each 60,000 population, there should be about 2,300 sanitary engineers in State and local health departments alone. Most public health agencies, as well as waterworks, sewage-disposal, and insect-abatement organizations, report acute shortages for established positions and urgent need for additional positions.

At the present only three schools are accredited for training sanitary engineers, but 27 other schools offer options in sanitary engineering as part of the undergraduate curricula in civil engineering. About

125 graduates degrees in sanitary engineering and about an equal number of undergraduate diplomas were awarded in the academic year 1947–48.

Confronted as we are by the critical personnel situation in the health professions, let us consider remedial steps. Our primary immediate need is to increase the output of the several types of schools, but we are faced with the hard fact that nearly all these schools require financial assistance in order to maintain present enrollments. We can hardly expect expansion commensurate with needs if every additional student increases the deficits—even to the extent of eating into endowment capital for current operations. The real danger of retrogression unless some relief is offered was a definite conclusion coming out of the conferences with deans which I mentioned earlier. The representatives of the schools will give you the specific facts during these hearings, but it seems obvious that the schools must have some financial stability for what they are now doing in order to undertake significant expansions. An assured income, not subject to wide fluctuations from year to year, is necessary to attract and keep an adequate faculty.

No one has detailed data on the costs of the various types of education and on the precise financial condition of the schools, so I cannot give the committee exact figures. The gross total of the budgets of the medical schools, however, is something over $50,000,000 per year and the income from tuition and fees is about $13,000,000. Thus the medical schools must find from such other sources as State appropriations, endowment income, gifts and grants, etcetera, nearly $40,000,000 each year. I do not need to emphasize the fact that gifts and bequests are increasingly rare, that the yield from endowment has been declining, that much of the available endowment is restricted to special uses, that grants for research and special projects are made on a short term basis and may or may not be renewed.

The other schools face a parallel, though not identical situation. The graduate schools of public health face a particularly acute financial problem; the average costs are seven or eight times the average income from tuition and fees. Only two schools have any appreciable endowment at all. The high costs in the schools of public health are because the instruction is highly specialized, the classes are small and are conducted on an individualized basis, and the faculty are engaged in full-time teaching.

In the schools of dentistry the average cost per student per year approximates $2,000—ranging from $1,050 to $2,350—and the average income from tuition and fees is about $500—ranging from $200 to $850.

With respect to the schools of nursing, it is important to remember that there are three kinds of schools involved. There are:

1. University schools with both graduate and undergraduate programs leading to degrees which prepare administrators, teachers, supervisors, public-health nurses, and nurses for special clinical fields;
2. Hospital schools with programs leading to diplomas, which prepare nurses for general bedside nursing in hospitals and homes; and
3. Practical nurse courses in vocational schools which prepare practical nurses to care for certain types of patients who are not acutely ill and to assist in the care of others.

Like the medical and public-health schools, the university schools of nursing have higher costs than many other undergraduate and graduate college programs because students must have close individual supervision during their clinical practice. Only a relatively few colleges can afford this heavy expense.

Because the hospital nursing school is such an integral part of the hospital, it is not possible to discern on the basis of present information whether the deficits are those of the nursing school or of the hospital. It must also be recognized that student service pays for a large part of the cost of training in some of these schools.

Coming now to the problem of the best method of providing aid to the schools, we believe that it is sound to rely on an objective formula—as provided in both bills—which is as self-executing as possible, which leaves the minimum amount of discretion in the Federal administering agency, and which gives the maximum protection to academic freedom.

Both bills recognize that the necessary information is not now available on which to base a confident statement of how much is needed and what the precise basis ought to be. The authors of both bills place a wise reliance upon a careful study, and both provide interim assistance on a per capita basis. Both bills provide for a partial contribution to the cost of education on the basis of present enrollment and for removal of the economic barrier to expansion. With both principles we agree.

The two bills differ on the extent of the Federal contribution to the cost of educating present enrollees. This difference is particularly evident with respect to medical schools. Thus H. R. 4313 provides for $300 per capita for each medical student while H. R. 4918 provides for $500. The latter figure may subsequently prove to be much nearer to what the schools will need on a continuing basis than $300, but we are confident that $300 per student will provide substantial help to the schools between now and the completion of the study. As I see it, the purpose here is to provide temporary emergency relief until the real needs can be determined. At least we are very sure that $300 per student per year will not prove excessive.

Similarly, the payments proposed in H. R. 4313 for other categories would be satisfactory as interim aid. They probably will later prove inadequate to put the schools on a sound financial basis, but the sums specified would be satisfactory in recognition of the necessity of selecting a figure somewhat arbitrarily in absence of all the facts.

Inasmuch as the schools are finding it difficult or even impossible to meet the costs of educating the current enrollment, significant expansion can be achieved only if the full cost of educating new students is met. The higher figures in H. R. 4313 for new students are based upon this principle. The average cost of educating a medical student is reliably estimated to be at least $2,200 per year, and the average income from tuition is $500. H. R. 4313 would make up the difference of $1,700 for each additional student in order that the medical school would not be hampered by increasing deficits as they expand. We feel this figure to be conservative; it is not a "reward," nor will it afford a "profit" to the schools. It is simply a payment of cost. The figure may undergo some refinement after the study contemplated in the bill, but it is the best we have, based on published figures of the annual budgets of medical schools.

The provisions of H. R. 4918 also follow the pattern of a higher figure for additional students, although the amount prescribed—$1,500 per student—is slightly lower than that provided in H. R. 4313. The formulae for schools of nursing are identical in both bills.

An important consideration in connection with expansion of enrollment is to ensure the preservation of quality of training. Concern has been expressed lest the incentive of a large differential in favor of new students might stimulate unhealthy expansion—unreasonable inflation of enrollment in existing schools or the establishment of "wildcat" schools. We believe that a substantial differential is necessary to achieve the primary objective of increasing the supply of health personnel. As long as the differential is limited by the principle of net cost which I have described, I see no cause for alarm. We are confident, moreover, that the control of quality may safely remain in the professional accrediting bodies, where it now is, as recognized by both bills.

I might point out that wise administration would eliminate any possibility of "wildcat" schools starting and allowing some of the poor schools to overenroll.

Further, in this regard, H. R. 4313 makes special provisions for the new schools which we anticipate will be established. It would be unsound to pay the full net cost for the entire student body of a new school. To do so would make the institution in effect a Government school. Section 372 (c) therefore provides that one-half the estimated average net cost per student be paid to new schools which are established during the interim period covered by the bill.

Parenthetically. I should point out that the provisions of both bills for aiding hospital schools of nursing differ in principle from those for aid to all other types of institutions. These provisions recognize that for training in these schools the primary problem is one of recruiting students. Instead of an outright financial grant to hospital schools of nursing therefore, the payments provide what is in fact an indirect scholarship. They are graduated, moreover, in accordance with the recognized fact that in each succeeding year student nurses give increasing amounts of service and thus are a diminishing expense to the hospital.

In the series of conferences which the Federal Security Agency held with deans and directors of schools of medicine, dentistry, public health, nursing, and engineering, the question of bottlenecks to expansion was discussed. The character of these bottlenecks was necessarily varied; in some schools it was the lack of teaching faculty; in others it was the lack of classroom and laboratory space; in still others it was the lack of clinical facilities.

At least half of the medical schools, nearly all the schools of public health, and many of the schools of nursing will require new physical plants—both new space and replacement space—before any appreciable increase in enrollment can be expected. For example, the deans of medical schools indicate that in their present plant not more than 5 percent additional students could be accommodated. It has been recently estimated by the medical schools that nearly $200,000,000 is needed for modernization and expansion. The schools of public health have needs which total over $20,000,000. Although the schools of dentistry do not require additional plants to accommodate present students, any substantial expansion will involve capital costs. Practically all the major nursing schools will need added space for classroom and living quarters.

Most of the professional schools have definite plans for construction of new and improved physical facilities but it should be clearly understood that a substantial part of the contemplated construction is to replace antiquated and inefficient existing plants for the maintenance of adequate standards in instructing present students. Many of these schools have already raised varying percentages of the total capital needed for such construction but are unable to complete their fund goals.

With regard to administration of title I of H. R. 4313, the Public Health Service is in complete agreement with the provisions governing the National Council on Education for Health Professions proposed in section 102. As you know, we have had a long and satisfying experience with advisory councils composed of both professional and lay representatives outside the Government. They have provided essential assistance and safeguards in the development of our important special programs in the fields of mental health, heart disease, and cancer as well as in our general research programs. They have made possible our record of assistance to and cooperation with nongovernmental institutions in the health field without interference with academic and scientific freedom.

The Public Health Service is in favor of Federal assistance to students who desire to take advantage of training for the health professions. This assistance is preferably given in the form of scholarships, although some consideration might be given to a combination of loans and scholarships.

It should be emphasized that the basis for financial assistance to students is quite different from the basis for assistance to the schools. Scholarships are primarily a device to equalize educational opportunity and to broaden the base for the selection of those who may receive advanced training. They will not necessarily contribute toward an expansion of enrollments. At the moment, for example, scholarships would do little or nothing to alleviate the shortage of physicians and dentists because the schools already have qualified applicants up to several times the present capacity. On the other hand scholarships are needed at once to attract students to the public health and nursing professions and to enable additional students to take advanced training. H. R. 4313 wisely does not undertake to specify the number of scholarships to be granted to each professional group. Congress can judge from year to year the factors affecting the need for scholarships and adjust appropriations accordingly.

Scholarship aid, under the provisions of H. R. 4313 would be granted on the condition that the recipient undertake, for a limited period following his training, to serve with a State or local health agency; to practice in an area designated by the State health agency as being in critical need of such health personnel; or—at the discretion of the State agency—to serve with a medical agency of the Federal Government.

I might point out that Dr. Hinsey, testifying before a Senate subcommittee last week, suggested that teaching and research in medical schools might also be considered as a means of working off the obligation. We are in strong agreement that such additional methods of working off the scholarship would be exceedingly useful. If the recipient should not fulfill this agreement to serve in one of these three categories of practice, he would be required to reimburse the Government for the cost of his scholarship aid.

Apart from any question of educational policy involved in a requirement of repayment by service, there are some indications that such a provision may prove difficult to administer and even ineffective. The available experience of private foundations and even of a few States suggests that scholarship holders who elect to repay in service may not observe their obligation to serve and that it may be difficult to require those who default to repay in money. The observation of repayment provisions over a few years would demonstrate whether or not they are workable.

The Commissioner of Education is here today to express the views of the Federal Security Agency on part B of H. R. 4313, pertaining to practical nurse training. I will therefore offer no comment on these provisions, other than to indicate that the Public Health Service is in complete accord with this approach to the training of these urgently needed members of the team of health workers.

Mr. Chairman, our statement has not been cleared by the Bureau of the Budget, but we understand that the Bureau of the Budget is sending the committee a communication in which it indicates its interest in these bills.

Mr. PRIEST. Thank you, Dr. Scheele.

Based on your own knowledge of the situation, Doctor, and on information obtained in this series of conferences held by the Federal Security Agency and the Public Health Service with deans and directors of medical colleges, deans of nursing colleges, and others, do you think it properly describes the situation facing the country, insofar as medical education is concerned, to say that it approaches the state of an emergency at this particular time?

Dr. SCHEELE. Yes; I think that on the average it is approaching an emergency, because of the shortage of funds in our medical schools. Now, some schools, of course, are in much better shape than others. There are a few schools where the need is exceedingly urgent. There are still a few that have fairly good endowments.

One can say, as a generalization, that our State medical schools are in somewhat better shape than the private schools, because the State schools have been able to fall back on State appropriations to assist them.

There is one other thing which is very difficult for ordinary medical schools. Many of them operate hospitals as part of their teaching program, and where they operate hospitals, they are having to absorb, at present, part at least of the high cost of hospital care as part of the cost of education of the students, and they do need some relief, we feel, very definitely.

Mr. PRIEST. That was my feeling, generally, when I said that I felt that it could properly be described as an emergency. I do not intend to imply that it is an acute emergency, but if it should develop very much further than it has at this moment, it could, in my opinion, become a rather acute emergency, and particularly with reference to those schools that operate hospitals.

I have had occasion in my own district to investigate some of those; one very fine one in my own home city, Vanderbilt University, where they also operate a hospital. I know the situation there and I know other similar situations, and it is my feeling that the type of assistance contained in this title of this bill and related bills which have been introduced, if of extreme importance at this time.

I shall not take further time to ask questions now. Perhaps there will be other questions from the other members of the committee.

Mr. Biemiller, do you have any questions?

Mr. BIEMILLER. Yes, Mr. Chairman.

Dr. Scheele, does your department have detailed data on the various schools as to enrollments, funds, and so forth? Can that be given in the course of these hearings?

Dr. SCHEELE. We have some data, but the data we have are taken essentially from published material of the American Medical Association.

The Council on Medical Education and Hospitals has at various times reviewed enrollment—in fact, annually—and has reviewed the physical situation in general. I believe witnesses from that council will appear before you subsequently. I think they are a better source of information than are we, because we would be referring to their data.

Mr. BIEMILLER. Mr. Chairman, I would like to observe at that point, that I think it might be well for the committee to request the American Medical Association's Council on Medical Education to supply us with that information, with regard to present and past enrollments, say, for the past 10 or 15 years.

Mr. WILSON. Mr. Chairman, I would like to join in that request.

Mr. O'HARA. I have the same thing in mind.

Mr. PRIEST. We shall request that information and I am sure that if it be possible for the information to be furnished, it will be supplied.

Mr. BIEMILLER. I have one or two more points I want to raise.

Mr. PRIEST. Yes.

Mr. BIEMILLER. I would gather from the body of your testimony that if you grade the critical situation in terms of relatives, that the worse situation at the moment is in nursing.

Dr. SCHEELE. It is very difficult, Mr. Biemiller, to grade, actually. It is worse in terms of absolute numbers. In other words, talking about whether it is tens or hundreds——

Mr. BIEMILLER. Percentage of shortage.

Dr. SCHEELE. Percentage of shortage. In terms of the critical situation, available money to finance the education, they are all exceedingly needy, but the schools of public health are, if anything, in worse shape than the medical schools, because they are regional and international schools. They do not restrict enrollment, to residents of their States, as some State schools do. Also they teach a group of people who go into Government service as career employees at relatively low salaries and, therefore, have no source of endowment from graduates and have to live pretty much on a shoestring.

Now, again, that situation applies to some medical schools, and it is very difficult to draw any gradation between them.

We feel that the whole team is involved; the whole medical and public health team is involved, as far as the critical situation is concerned. I think it is almost impossible to draw any objective line on a priority basis.

Mr. BIEMILLER. I note on page 5 of your testimony you say that many hospital wards are now closed for lack of nurses.

Is that in both private and Government hospitals?

Dr. SCHEELE. Yes, sir; that is correct. Probably fewer are closed in Government hospitals on that basis than in private.

Mr. BIEMILLER. Can you give us some estimate as to the number of beds that might be involved in that situation?

Dr. SCHEELE. No, sir. We refer here only to the general situation which we know exists. We have no detailed information. To my knowledge, no survey has been made of the actual number from time to time that might be closed.

Mr. BIEMILLER. That is all, Mr. Chairman.

Mr. PRIEST. Mr. O'Hara?

Mr. O'HARA. Doctor, do you have any estimate of the required plant facilities that would be necessary for the several schools and universities throughout the country, that will be needed to bring plant facility itself up to what would be needed in your estimation?

Dr. SCHEELE. Mr. O'Hara, again I do not like to appear to evade answering questions which the members of the committee ask me, but——

Mr. O'HARA. I would not be asking this, but it seems to me that this is something we should have from someone.

Dr. SCHEELE. I believe you will have testifying before you, in a very short time, Mr. Anderson and Dr. Weiskotten from the Council on Medical Education and Hospital of the AMA—and also you will have Dr. Hinsey, from the Association of American Medical Colleges. They have done some actual surveys on the construction situation, and with the committee's permission and with your permission, I think it would be preferable for them to answer, because they have the data on hospital costs. I think they estimate that about $200,000,000 construction is needed for medical schools and they can define that construction need with greater accuracy.

Mr. O'HARA. That would apply to private——

Dr. SCHEELE. And State.

Mr. O'HARA. And State schools.

Dr. SCHEELE. Yes, sir. The schools are roughly divided half and half.

Mr. O'HARA. Doctor, is there any difference as to the number of medical students—I understood you to refer particularly to medicine and surgery—and during the war, was the number of medical students greater or less than today? Do you know?

Dr. SCHEELE. During the war, the number was greater, because we had a speed-up in education. The schools operated through the year, and were able to turn out a larger number.

Again, I think Dr. Hinsey would be the ideal witness to give specific figures on that.

Generally speaking, our observation is that in wartime and now, discounting speed-up, the schools are pretty well at their maximum in terms of numbers they can teach, and there has not been any appreciable change in that situation from the wartime to the present time.

The difficulties are (1) in the hospitals; (2) in obtaining good faculties because of low pay scales; (3) in available classrooms for some of the didactic work—anatomy and some of the other classroom courses; and (4) in some instances, in lack of clinical facilities. These factors have held the numbers that the schools could enroll quite constant during the last eight or so years.

Mr. O'Hara. Doctor, is it or is it not true that medical schools generally throughout the country do not take any more students today than they did 15 or 20 years ago—approximately the same?

Dr. Scheele. Again, I would like to leave that to the experts. My impression is that they take quite a few more now than they did in those days.

Mr. O'Hara. Probably not as great an increase as the increase in population?

Dr. Scheele. Some of the figures that are quoted are occasionally a little off base. Sometimes we refer to the figures of 30 or more years ago and the numbers of schools, but actually at that time we had many schools that were proprietary schools which were very poor. They were totally inadequate. A very excellent job has been done in setting standards for education, and many have been eliminated.

Mr. O'Hara. Some of the so-called diploma mills have been run out of business?

Dr. Scheele. Yes, sir; they have been run out of business, and so, in taking figures over a long period time, it is not quite fair to make comparisons. On the other hand, we feel very strongly that without the kinds of assistance that these bills provide, namely, some sort of a basis for current education and some construction, our current enrollment is not going to be maintained, and that to maintain it is going to become increasingly difficult, particularly in a period of economic decline.

Then beyond that, too, we see as our major objective this difficulty, namely, improving the health care of the people of the country. That means training more personnel to fill our shortage areas where they need additional personnel; but each new student added is an additional burden to the schools. Medical education—and this applies to most professional education in the medical field—is one of the most costly types of postgraduate education that our universities have. The cost of training men and women in almost any other field than medicine, for example, is considerably less costly to the university than this training in medicine, which requires hospital operations, a variety of kinds of conditions and approaches and a variety of faculty and equipment. The medical school is in fact a drain, very often, on the endowment or on the total operation of the university.

I might say in that connection that there is a great deficit between the tuition and fees of the student and the actual cost to the university in providing the education to him in any given year.

Mr. O'Hara. What do you estimate would be the aid granted to the schools in connection with the education of the student? Would that be separate and distinct from that which would be considered as increase of plant facilities of the school?

Dr. Scheele. Yes, sir. We would consider those as separate, shall we say, line items in the program. The base money given to them would depend on enrollment, current enrollment, based on the enrollment over a period of several preceding years. This would be money for the school to use in employing additional faculty members; making adjustments to improve faculty generally; for certain equipment, teaching aids, I should say, rather than equipment, and for improving clinical facilities. In addition, we have another program, in a sense, in which we come more nearly to paying the cost of increasing enrollment. Many schools would have to add still further classroom space and teaching facilities, as well as clinical space, to enable the schools to expand. Not all schools could expand equally. Some schools undoubtedly should not expand at all. Some probably have reached the maximum at the present time. Other schools could expand substantially.

Mr. O'Hara. Would you say generally, Doctor, that the medical schools of the country, both private and public schools, have been running to capacity for a good many years?

Dr. Scheele. Yes, sir; that is my impression.

Mr. O'Hara. Certainly the last 15 or 20 years?

Dr. Scheele. Yes, sir; I think that would be a fair statement—10 years would be a fairer estimate.

Mr. O'Hara. Is it also true, Doctor, that the number of students who are permitted to enter and the number who cannot enter, who are eligible to enter, is quite large?

Dr. Scheele. Yes, sir; there is a great spread. Of course, the number of applications, the total number of applicants, is a figure which is higher than the number of students applying because many of them shop around and apply to many places. In spite of that there are many more applying than can get in. That is especially true in some of our less populous States, and particularly in States that do not have State medical schools. Sometimes our State schools have to, under State rules of procedure, accept primarily students from within the State, because they are supported by the taxpayers of the State. Therefore, the students of nearby areas have great difficulty in getting in.

Mr. O'Hara. Well Doctor, one of the first things we have to consider is what can be done as to increasing facilities of the medical schools; is that not correct?

Dr. Scheele. Yes, sir; although simultaneous with this something has to be done. I interpret facilities in that case to be bricks and mortar.

Mr. O'Hara. Plant.

Dr. Scheele. Simultaneously something has to be done as to faculties and teaching aids and other things.

Mr. O'Hara. I appreciate that those all go together. Now, one other question. I note that you recommend the very worthy proposition of scholarship aid.

Do you think that any doctor who becomes a doctor, who would get his tuition taken care of by the Government, and do you think that anyone who was so educated at Government expense, that there is any reason in the world why he should not pay back to the Government whatever amount had been expended on him? I am thinking of paying back in terms of dollars and cents.

I think probably on this committee there are quite a few members who worked their way through college without any aid from anybody other than their own hands, and there are various other professional schools that have no such consideration; various other educational institutions which are as important perhaps as the field of medicine, in which the scholar would not have that advantage of Government assistance.

It is a rather discriminatory problem, is it not, Doctor?

Dr. SCHEELE. Yes, sir; it is, and I certainly agree with you that there is no reason not to require that a student be required to pay back his loan.

On the other side, I would only say one or two things. Medical education is very lengthy education.

Mr. O'HARA. Very confining.

Dr. SCHEELE. As it is in a few other professions, certainly in law, although I believe medical schools require a longer time, because the medical student has to go on with his internship, and now we find even to become a general practitioner he has to take a residency which takes him 1 or 2 or 3 years longer than even his internship period. So that carries a man pretty well along in life. He ordinarily, by that time, will have married. He may have a family. He has, in the course of living in the community, taken on other obligations which are normal obligations to take on, of course, and yet at the age of 30, as he comes off the mill, to start to work, he is faced with having to pay back a debt.

One can also moralize on the other side and say that the health professions, like the clergy, are noble professions. People die when they get sick, if they are sick enough. From purely humanitarian principles, one might say that maybe society could afford to educate some of the poor boys who cannot afford, on their own, to put up the money to go through medical school and might carry this cost as a sort of public charge.

On the other hand, I do agree that the proposals here are sound, and I think that one could well try them for awhile and then, based on experience, when we see what happens later, modify them if the Congress saw fit and experience indicated it.

Mr. O'HARA. Of course, we all know we are going to die anyway. That is certain.

Dr. SCHEELE. Then I would like to point out one more thing, because this came up in connection with the study and training by the Army and Navy during the wartime. Psychologically, there is a very peculiar situation which arises, in spite of the moral obligation to repay something. When we go out and get a loan from a bank, we know we owe the bank something. We know that they will foreclose on our property if we do not pay the bank. Yet, strangely enough, when it gets down to a man's personal services, a man working with his hands and head, once the time of education passes and he sees his competitor is doing other things outside, it is very difficult for him sometimes to adjust himself to giving services or maybe even paying back the money. It is not a question of moral obligation; it is a question of what happens to the individual in his thinking. Sometimes it is a question of what we can hope to accomplish rather than a question necessarily of what is completely legal or morally correct.

Mr. O'HARA. Well, it is true, Doctor, that under some of these very worthy objectives, some of these youngsters who were going to be drafted wanted to go to medical school and the Government educated some of them in various programs and some of them never served a day. They had their education paid for and were paid for going to school on top of that. Is that not true?

Dr. SCHEELE. That is correct.

Mr. O'HARA. I wonder how many thousands of those there are who never rendered any services to the Government.

Dr. SCHEELE. We do not have those data. We can get those for the committee if you wish.

Mr. O'HARA. I wish you would give us a report on that.

Dr. SCHEELE. Yes, sir; we can check with the Army and the Navy and get the figures. Possibly some of the other witnesses may have those figures.

(The information is as follows:)

FEDERAL SECURITY AGENCY,
UNITED STATES PUBLIC HEALTH SERVICE,
Washington D. C., June 21, 1949.

Hon. J. PERCY PRIEST,
House of Representatives, Washington, D. C.

DEAR CONGRESSMAN PRIEST: When Surgeon General Scheele appeared before the Health Subcommittee on June 9, 1949, he testified on title I of H. R. 4313. Congressman O'Hara asked how many medical students who received their training under the Army AST and the Navy V-12 programs during the war had rendered no service to the Government.

The information on the attached page was provided to us by the Secretary of Defense's Medical Advisory Committee. It contains the best information available in answer to Mr. O'Hara's question.

Sincerely yours,

C. L. WILLIAMS,
Acting Surgeon General.

Status of participants in medical training programs of World War II, as of Dec. 31, 1948

1. Total medical participants	31,176
Army ASTP	20,000
Navy V-12	11,176
2. With service as medical officers	17,903
Army	12,500
Navy	5,403
3. Separated for physical, academic, and other reasons	4,262
Army	3,000
Navy	1,262
4. Available for service as medical officers	9,011
Army	4,500
Navy	4,511
(*a*) Estimated disqualified for physical, academic, and others	1,066
Army	750
Navy	316
(*b*) Estimated deferments (1/6 over-all allowance)	1,502
Army	750
Navy	752
(*c*) Net available	6,443
Army	3,000
Navy	3,443

Mr. O'HARA. I guess I have used up my time, Mr. Chairman. We have a 5-minute rule.

Mr. Priest. Mr. Wilson.

Mr. Wilson. Mr. Chairman, I want to ask the Surgeon General a question about sanitary engineers.

I see on page 6 of your statement that you talk about the deficiency in personnel, and among those you include sanitary engineers.

Dr. Scheele. Yes, sir.

Mr. Wilson. You say "only three schools are accredited for training sanitary engineers." What are those schools?

Dr. Scheele. One is Harvard, one is Pennsylvania State—I believe the third is Rutgers University. And then beyond that it is a matter of an engineering school at, say, the University of Michigan, allowing the student to take the regular engineering course with an option or major, in sanitary engineering. Schools offering sanitary engineering are accredited by the Engineers' Council for Professional Development. Schools of public health are accredited by the American Public Health Association, which has a parallel function with that of the American Medical Association as to medical schools. The American Public Health Association reviews the curricula and standards generally of the schools of public health and either accredits them or does not accredit them, based upon those findings.

In this instance, it does not mean that the other engineering schools. which give options in sanitary engineering, are not turning out good sanitary engineers. They are. But to be accredited ordinarily means that a bit more emphasis in sanitary engineering, and specializing, in general, in public health is required.

Mr. Wilson. Now, you state on pages 3 and 4 of your statement, based on conservative estimates—you refer in this projection to the year 1960—that there will be an anticipated shortage of doctors of 15,000 and dentists of 5,000.

What is the basis of that estimate?

Dr. Scheele. With your permission, Mr. Chairman and Mr. Wilson, I would like to call on Mr. George Perrott, who is the Chief of our Division of Public Health Methods, to answer your question.

Mr. Perrott. The basis of the estimate for the 15,000 shortage of physicians by 1960 is as follows: Estimates were made of the number of active physicians to be expected in 1960 at present rates of graduation and taking account of deaths and retirements. That gave a figure of about 212,000, as I remember, that we would expect in active practice by 1960 at the present rates of graduation, and with some assumptions as to certain new schools getting underway that are now either contemplated or actually started.

Then we estimated the needs in 1960 as follows: We assumed that there would be no change of demand for doctors' services from the point of view of the general practitioner, for example. We calculated the additional needs that would be produced by eventual building of new hospital facilities under the Hill-Burton Act, assuming that that would go forward until 1960.

There is obviously some crystal gazing in all of this forecasting, but we assumed that that building would go on. We then assumed that there would be an expansion in local health units, and that there would be a need for personnel in those units. We estimated as well as we could the peacetime needs of the armed forces—needs that they say they have at the present time—the Public Health Service and the

Veterans' Adminstration. We added those together to get the number of doctors needed in 1960, which as I remember was 227,000, so that 227,000 minus the 212,000 we estimate we might expect in 1960 gave the 15,000 figure.

In the case of the dentists I think no one believes that it would be possible to actually meet the real needs for dental care in the United States, the need as distinguished from the demand, the ability to pay, because that would be quite high. But it was felt that in view of the increasing health consciousness of the population and in view of some of the educational programs in connection with the need for dental care, and expansion of public-health programs, an increase of some 5,000 over what we might expect in 1960 would be justified.

Mr. Wilson. In using the formula that you have mentioned in calculating the expected number of 227,000 as needed, what percentage of doctors per thousand would that be, still using the crystal gazing, of how many people we think we will have in 1960?

Mr. Perrott. What ratio of doctors to population would that be, you mean?

Mr. Wilson. Yes.

Mr. Perrott. Well, if I had a minute I could divide it out. It would be 227,000 divided by 153,000,000. I think the Census Bureau estimate was something like that. The baby boom of the last few years has resulted in an expected population in 1960 a good deal higher than it was thought it would be 4 or 5 years ago.

Mr. Wilson. We had a similar baby boom after World War I, if I remember correctly.

Mr. Perrott. That is right.

Mr. Wilson. May I speak again to the Surgeon General and call to his attention that on page 7 of his statement, in talking about the income of the medical schools and where they are going to have to get the income to meet the increasing needs, you speak of yield from endowment, that it has been declining. Why is that?

Mr. Scheele. I presume because most investments these days do not yield so high a rate of interest as they did in the past.

Mr. Wilson. That ic certainly sound reasoning, that the yield of money today is not so great as it was, but why are there not as many endowments as they were, in the same ratio or level as there has been in the past? Do you know the reason for the falling off of gifts and endowments to schools?

Dr. Scheele. I think most of the problem is an economic problem rather than any problems of interest in medical education or medical schools in particular. We do not have so many large fortunes in the country today as we did in former years, and we do not have people who are giving huge endowments as we sometimes did in the past. There are only a few of those in prospect at the present time, that we know of.

I suppose today there are more demands on the relatively wealthy individual's philanthropy. Where formerly he might be asked to help a medical school or a particular university or some other part of a university, today he is being asked to help a greater variety of causes. That leads to some diffusion. We have the equivalent of endowment going into cancer and heart diseases and going into a variety of things, all of which are tied probably to what we believe to be a fact: namely, that there is less opportunity in the future for the medical schools to receive substantial endowments.

Mr. WILSON. The next paragraph of your statement says that only two schools of public health have any endowment at all, and even in those schools it is very small.

Dr. SCHEELE. That is in the schools of public health. A school of public health is a far different proposition. The school of public health trains workers, essentially, to work in city and county health departments, or the Federal Government. The people who go into those professions, the so-called public-health professions, never have an opportunity to earn much money, so they do not become endowers of their schools. The school is nt dealing directly with the saving of a specific life or does not have a direct contact with a person who is potentially an endower of the school. Most people are not so aware of the schools of public health as they are of individual medical schools. A medical school may have a professor of surgery or a professor of internal medicine who has a wealthy patient, and that patient feels he owes society a debt because his life has been saved by that individual, and his attention is focused on the medical school.

The public-health worker has no clientele except the public at large, and basically their clientele are the poor people. They are giving services to the underprivileged and therefore not making the kinds of contacts whereby their school is called to the attention of individuals who would give them money.

Mr. WILSON. Doctor, our population has been ever increasing, and our resources, our money, our finances have increased as we have increased in population, and yet at the same time, those interested in endowment of a medical school have decreased. Whatever those factors are that enter into that picture it is a fact, is it not, that such is the case?

Dr. SCHEELE. I cannot give you a categorical "yes" or "no" as an answer. It has happened in part, but I would also point out that the costs of medical education and hospitalization and hospital teaching have gone up so that actually some of what we are talking about in lessened endowment and lessened support is actually, dollar-wise, greater, but need-wise less. I do not know whether I make myself clear.

Mr. WILSON. I understand.

Dr. SCHEELE. There are many factors, and it is not a clean-cut thing.

Mr. WILSON. Could it be that there is a factor that more people are saying in our Nation: "Let Uncle Sam do it, do not put your money in endowment and gifts in a medical school, they will be taken care of some way from the public dollar, and we will interest ourselves in research in petroleum, and we will interest ourselves in research and advancement in aviation and Uncle Sam can take care of the increase, or the endowment, the care of the cost of the bricks and mortar as well as the professor and the instruments that are used in the very thing that we need, to help get more doctors in our medical schools, and more students there, and more ample provision made for training them"?

Could it be that more people are saying, "We will leave it to Uncle Sam"?

Dr. **Scheele.** No, sir; it is my belief that that is not the case, and as evidence that it is not the case, I would point to the increased public support of voluntary health organizations—for example, the American Cancer Society has grown from half a million dollars 4 or 5 years ago to $14,000,000 now. We cannot quote specifically, but I think if you visit most hospitals around the country you will see evidence of it. There is vastly increased endowment and support of beds in our expanding hospital program of the country so that the money is still pouring out, the philanthropy is still pouring out to assist health programs.

I think that a part of what we are talking about when we speak of endowment is that we speak of the million-dollar gifts and the sizable gifts.

Mr. **Priest.** Are there any other questions?

Mr. Dolliver, a member of the full committee, is substituting here for Mr. O'Hara on the subcommittee for the time being. Do you want to ask a question?

The Chair was notified and makes this statement at this time for the benefit of Dr. Scheele: that he has to catch a plane pretty soon for New York, so we will be as lenient as possible with the doctor from here on out.

Mr. **Dolliver.** I just wondered if you could give the committee the benefit of any knowledge you may have as to the substantial amounts that are now being spent by private endowments and foundations for medical education institutions.

Dr. **Scheele.** Possibly Dr. Anderson, who is to testify later, may have that data in the AMA study of financing of medical education.

Mr. **Dolliver.** The proposal which you are supporting in this bill you envision as a supplement to that, or as a parallel to that; is that right?

Dr. **Scheele.** As a supplement, I think, would be the way we would like to put it.

Mr. **Dolliver.** Now, you mentioned in your statement, which I have glanced over but unfortunately was not here at the time it was given, there is a great shortage of medically trained men and also of dentists.

Would you say that any substantial portion of that shortage is due to the recent war and the diversion of our young men into the armed services rather than into college and professional schools?

Dr. **Scheele.** No, sir; because our medical schools are operating at capacity and they are turning down students who apply for admission at the present time. I think that we are operating at full capacity and our shortage is related not to the war but it is related to the fact that medicine has a great deal to offer these days. More people want to be taken care of medically, so that we are thinking more and more these days of distribution of medical manpower and the availability of care to people.

Mr. **Dolliver.** And is it your view that this shortage is not the result of anything that has taken place in the recent past, but in the first place it is based on the limited facilities which we have for training medical people and, secondly, on the increased demand for those services?

Dr. **Scheele.** That is correct.

Mr. PRIEST. Thank you, Dr. Scheele, and we appreciate your appearance before the committee.

The next witness will be Dr. Earl J. McGrath, Commissioner of Education, Office of Education of the Federal Security Agency.

Dr. McGrath, will you proceed?

STATEMENT OF DR. EARL J. McGRATH, COMMISSIONER OF EDUCATION, OFFICE OF EDUCATION, FEDERAL SECURITY AGENCY, ACCOMPANIED BY DR. R. W. GREGORY, ASSISTANT COMMISSIONER FOR VOCATIONAL EDUCATION, OFFICE OF EDUCATION, FEDERAL SECURITY AGENCY

Dr. McGRATH. Mr. Chairman, I welcome the opportunity to appear before this subcommittee to discuss the provisions of House bills 4312, 4313, and 3894 insofar as they deal with the training of practical nurses. While such a training program must quite properly be considered as an integral part of a total program for the training of health personnel, I shall necessarily limit my remarks and shall not undertake to discuss all the provisions of these bills as they pertain to the education of other types of health personnel.

The Public Health Service has estimated that 276,500 practical nurses will be needed in the next 10 years; that at present we are training for the Nation as a whole only about 2,000 a year. There is thus an increasingly pressing need at the present time for practical nurses to serve in hospitals of all types, in homes for the aged, in industrial plants as assistants to visiting nurses and public health nurses, and in private homes.

The growing realization of the important part that the practical nurse should be prepared to play in the provision of more adequate health services for the American people is of comparatively recent origin. It springs in some measure from such studies as the one prepared by the Russell Sage Foundation for the National Nursing Council and published under the title: "Nursing for the Future," from which I should like to quote a few pertinent excerpts. Says this report, on page 45:

> In spite of all attempts, there is little real hope that an adequate supply of graduate nurses can ever be obtained if demand remains insistent—

and on page 60:

> It was tacitly assumed that once the war was over the hospitals * * * could get back largely to a graduate and student nurse basis. * * * The record since 1945 has demonstrated the error of that presumption. The bitter truth is slowly being borne in on those responsible for planning that—

the demand is great and there is no considerable body of nurses to meet it.

I should like to interpolate at this point that as dean of the College of Liberal Arts at the University of Iowa, in the postwar period, I had some responsibilities for working with the medical school in the nurse training program. We were hopeful that after the war was over an adequate supply of nurses could be turned out to satisfy the needs of the hospitals of the State of Iowa, to say nothing of those in adjoining States. But it soon became apparent that we could attract very few girls, relative to our needs in Iowa, on the basis of the present requirements. That is in the nurse training program requiring a bachelor's degree. So my experience leads me to agree with the report of the Nursing Council that:

> The task of the future therefore seems to be that * * * of fashioning a functional system in which * * * persons of many different skills may render efficient service in the area of the health services.

Chapter III of the report indicates that the answer to the shortage of nursing services lies in a differentiation of nursing service, and goes on at pages 58 and 59 to point to the practical nurse as—

> the only considerable source for staffing groups of institutions that probably contain over one-half of all the hospital beds in the United States.

The attention of the committee might well be directed also to an article in the Saturday Evening Post of May 28, 1949, which dramatically describes the need for practical nurses in hospitals and homes and goes on to tell of some existent programs in the public schools for training practical nurses.

I do not know how many of the committee are acquainted with the federally aided program of vocational education established under the Smith-Hughes Act of 1917 and supplemented by subsequent Federal acts, the latest of which is the George-Barden Act of 1946, or that this program has for the last 25 years included some classes for the training of practical nurses.

Under the provisions of the Federal vocational education acts such training can be provided only as it is included as a part of trade and industrial education. The classes are conducted by local public schools. The cost is reimbursed in part from State and Federal funds for vocational education. The training in all cases includes practical experience in cooperating hospitals. At present, 50 classes operating in 22 States graduate approximately 1,100 practical nurses per year.

Classes average about 20 students. The courses run from 9 months to a year in length. The greater proportion of the time in the first part of the course is spent in class work. The latter part of the course is largely devoted to practical experience in a hospital under immediate medical and nursing supervision. Graduate nurses are used as instructors and supervisors.

At present, vocational schools are training over one-half of all the practical nurses receiving training, meager as that number may be. The number is not larger because this program under present Federal legislation can be only an incidental phase of vocational education operating with limited funds also in very great demand for trade and industrial training and subject to certain limitations which, while they may be appropriate for machine trades or carpentry, and the like, are not so suitable for training practical nurses.

Nor has the Office of Education been oblivious to the need for promoting insofar as presently possible the organization and upgrading of classes in this field. Nurse Associations and the Vocational Division of the Office of Education prepared and published in 1947, An Analysis of the Practical Nurse Occupation, as a basis for improving the training of practical nurses. This bulletin has been a "best seller." A second bulletin, cooperatively prepared, dealing with the curriculum in practical-nurse training is nearly ready for the printer.

Both the report of the Russell Sage Foundation and the article in the Saturday Evening Post previously cited devote much space to a description of the training of practical nurses in the federally aided vocational education program.

I should like to emphasize that the Federal, State, and local administrative machinery for expanding this training program already exists under the vocational education acts. It is quite as ready to step up this training program as it has proved ready in meeting other emergencies in the past. All it needs is the stimulus that additional Federal funds and the provisions contained in title I, part B of H. R. 4312 and identical bills would provide. For example, in 1940, a War Production training program using this same Federal-State-local administrative machinery and facilities for vocational education was launched within a few days after Congress had made the necessary appropriations. Under that program over 11.5 million people were trained for hundreds of different jobs by the end of the war. The same organization was then quickly adjusted to carry a training load of thousands of veterans seeking training under provisions of the GI bill of rights. In short, the Office of Education and the States have an acceptable and proven pattern of training with adequate experience in administering a training program of the type contemplated by part B of title I, H. R. 4312, 4313, and 3894.

Let me repeat that facilities for training practical nurses under the present federally aided vocational education program are severely limited. Current Federal vocational education acts, while they have been interpreted to permit the use of funds for this training, were not written with any recognition of the needs or peculiarities of the practical nurse training nor with the idea of coping with an emergency need such as the present demand for practical nurses. For that reason we favor these major provisions of the proposed legislation which we think would: one, support the program entirely from Federal funds for 5 years followed by an increasing scale of matching for a period of 4 years and by a dollar-for-dollar matching of Federal by State funds thereafter; two, provide a maximum of $2,500 to each school for alteration of public buildings necessary to provide adequate training facilities; three, liberalize time requirements now contained in the vocational education acts and other limitations with respect to type of class and enrollee; four, provide a more flexible basis for the allotment of funds to the States. One-half of the funds would be allotted among the States on the basis of population, the other half on the basis of need; five, in recognition of the emergency need would provide for special promotion of the program, including recruitment of students and teachers.

Through the provisions of this legislation, present State staffs in vocational education could be quickly augmented by an average of one professional person in nursing education per State with provision for necessary travel and other expenses in initiating, promoting, and supervising the operation of the program. The present Federal staff, augmented by a few professional persons in this field with provision for necessary travel, clerical assistance, and other expenses, could assist the States in the promotion and guidance of the program.

Local school would provide space, necessary teachers, make arrangements with local hospitals for clinical training and otherwise operate the training programs. Classes would be provided for high school seniors and out-of-school persons on a preparatory basis. Classes could also be provided for refresher type training of experienced persons not currently employed as practical nurses.

Experience such as that in Michigan has shown that even small cities can operate a practical nurse-training program successfully. Such training under the provisions of part B of title I could be made easily accessible to all parts of the country, and so would tap a new and extensive source of practical nurse training supply.

It is estimated that, in the first year of operation under the proposed legislation, 375 training centers could be gotten under way to train 15,000 persons for entry upon employment as practical nurses and also to give short refresher or extension courses for 10,000 additional persons already employed as practical nurses. On the basis of actual costs of such courses in New York, Virginia, New Jersey, Washington, Delaware, and Connecticut, it is found that instructional costs would average $240 per person for the full preemployment training course in 1 year and 30 cents per hour per person for the shorter training for employed persons. Total estimated costs for salaries of instructors for the first year would thus for $3,600,000 for preemployment courses and $90,000 for refresher and extension courses.

On the basis of the costs of equipment at the centers mentioned above, an estimated $6,500 would be required for each center. Thus, for 375 centers equipment costs are estimated at $2,437,500.

If each of the estimated 375 school training centers would spend the maximum of $2,500 allowed in the proposed legislation for alterations of public buildings, that would cost $937,500.

It is estimated that the additions of an average of one professional nurse educator to each State staff, 51 States and Territories, plus other necessary State costs, would amount to $1,040,400 for the first year; addition of six such professional staff members to the Office of Education plus other necessary expenses would amount to $116,628.

The total costs for the maximum possible program for the first years are thus estimated to come to $8,222,028. It is proposed to step up the program in succeeding years at the rate of from $2,000,000 to $3,000,000 more per year until the maximum authorized appropriation would be reached.

In conclusion, let me say that I hope that the committee will recognize the urgency of the need for expansion of the training program for practical nurses; and that you will realize the advantage of using the existing facilities of public schools, States, and of the Office of Education in launching such an expanded program.

Again let me thank you, Mr. Chairman, for the opportunity to testify on this matter. I shall be glad to try to answer any of your questions on the proposed practical nurse training program; and if because of my relatively brief experience in the office I cannot give you a ready answer, Dr. Gregory, the Assistant Commissioner for Vocational Education, and Miss Arnstein of the Public Helath Service are here to provide assistance.

Mr. Priest. Thank you, Doctor. Let me ask you this question: As I understand you, you said the part B of title I on which you are giving testimony, the annual cost as anticipated, would be about $8,000,000.

Dr. McGrath. Yes, $8,222,028.

Mr. Priest. Are there any other questions?

Mr. Dolliver. I would like to make an inquiry from Dr. McGrath. He comes from the State of Iowa, as I do, and I would like to ask about the nursing situation there to which you alluded in your testimony.

Now, to what do you attribute that shortage? Is it that the young women are not interested in the profession of nursing? Is it because there are no facilities available for their training? Or is it because the future prospects of remuneration in the profession are not sufficient? Would you comment on those questions, please?

Dr. McGrath. Yes. I think it is all three. In the past, at that institution and at another, the University of Buffalo where I served for some 20 years, following the nursing profession very closely, it was possible to get, I will not say an adequate supply of nurses, but it was possible to maintain a rather large training program in connection with the local hospitals.

Now, in Iowa, to get back to your question about the numbers of young women entering we stepped up the requirements for the bachelor's degree in nursing to the point where 3 years of nurse training were required, and 3 years in a liberal arts college, which made the course almost as long as the medical course.

The first year that requirement was in effect I think we got 15 applicants, and we needed some 125. Now, obviously we could not staff the university hospital and we could not continue to staff it if we continued those requirements. The result was that that program has been modified and I think now it is possible for a girl to get a bachelor's degree in about four calendar years, which would be something more than the usual four academic years. I think the training program is too long for a large number of nurses. Let us say we need, as it is said here in the report from the Public Health Service, by 1960 we will need 402,000 professional nurses, and 248,000 practical nurses of the type we have described, merely to adequately staff the hospitals, as we can see the picture now without any improvement in service.

Now, we may be able to get 400,000 girls in that long, professional program, but if we are going to get a complete service, I am sure that we need a shorter program that will attract girls who do not want to spend from 4 to 6 years to get a bachelor's degree to become a nurse.

Now, the practical nurse, then, will attempt to fill the gap left vacant by these other programs.

Secondly, I am not prepared to give you definitive information on the effect of salaries of nursing on recruitment. I would venture the guess as in the profession of teaching where, as you know there is not an oversupply of elementary-school teachers, that many girls, seeing their sisters enter some other industry at $35 or $40 or $50 a week at initial employment with nothing more than a high-school education, that some of those girls have been deterred from entering nursing, as well as teaching by the lack of a differential in salary.

Now, there are other factors which I think no one has information on, and that is the relative attractiveness of one kind of occupation as against another, and those are quite intangible things.

Mr. Dolliver. Thank you. That is all, Dr. McGrath.

Mr. Priest. Dr. McGrath, we appreciate your testimony. Dr. Gregory accompanied you, but I think he did not anticipate making any statement unless called on for information; is that correct?

Dr. McGrath. That is correct.

Mr. Priest. Thank you so much for your appearance.

Mr. Priest. Our next witness will be Dr. Weiskotten of the Council on Medical Education and Hospitals of the American Medical Association.

STATEMENTS OF DR. HERMAN G. WEISKOTTEN, COUNCIL ON MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION, SYRACUSE, N. Y.; AND DR. DONALD G. ANDERSON, SECRETARY, COUNCIL ON MEDICAL EDUCATION, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

Dr Weiskotten. I appreciate the opportunity, Mr. Chairman, of presenting a statement.

Mr. Priest. It is the understanding of the Chair that you are accompanied also by Dr. Anderson, and he will present a part of the testimony, and Mr. Victor Johnson, who was also scheduled to be with you two, is not here today, but you and Dr. Anderson will present the testimony?

Dr. Weiskotten. That is correct.

Mr. Priest. You may proceed, Doctor.

Dr. Weiskotten. I am Dr. Herman Weiskotten, of Syracuse, N. Y. I have served on the faculty of Syracuse University College of Medicine for 40 years and have been dean of that medical school for 27 years. I am representing the American Medical Association. My official position in the association is that of chairman of its Council on Medical Education and Hospitals. This council consist of seven leaders in medical education selected from all regions of the country.

I am accompanied by Dr. Donald G. Anderson of Chicago, former dean of Boston University Schol of Medicine and at present the executive officer of the Council on Medical Education and Hospitals of the American Medical Association.

With your permission, Congressman Priest, I should like to call upon Dr. Anderson at this time.

Mr. Priest. Very well.

Dr. Anderson?

Dr. Anderson. The Council on Medical Education and Hospitals, and its predecessor, the Committee on Medical Education, has functioned for a century. The work of the council has been a major factor in establishing and maintaining the higher standards of medical and hospital care in this country since the quality of a physician's services can be no better than the quality of the education he receives as an undergraduate in medical school and later as a hospital intern or resident. Early in the present century intensive efforts were initiated to improve medical education in this country.

Dr. Scheele has already referred to the fact that some of the medical schools were still operated primarily for the financial profit of the faculty and provided exceedingly inferior instruction. In 1908, at the instigation of the council, the Carnegie Foundation conducted a survey of medical schools, under the direction of Abraham Flexner, and with the collaboration of representatives of the council. The findings in this survey, constituting the classic publication generally known as the "Flexner report," resulted in the closing of a number of inferior schools. These were schools scarely deserving the name, and produced graduates obviously unqualified to treat the sick. The effect of the Flexner report was remarkable since it was not supported by legal or governmental authority, but produced results entirely through its influence on public opinion.

Through the ensuing years to the present time, the recommendations of the Council on Medical Education and Hospitals still derive their effectiveness, not from legal authority, but from public opinion, lay and professional. This opinion recognizes the objectivity of the conclusions of the council in its efforts to improve medical education and, as a consequence, the quality of medical care.

In our work we compile the statistics that Dr. Scheele referred to on the activities of the medical schools and publish them in the annual educational number of the Journal of the American Medical Association.

I have with me one copy of the latest issue which I shall be glad to leave. I shall also be glad to send additional copies to your committee. This issue gives full information on enrollments over the years, and information on the different enrollments in the different schools.

Mr. PRIEST. Thank you very much. We wanted that information, and it will be most helpful to us.

Dr. ANDERSON. All three bills under consideration by your committee today are of fundamental concern to medical education in this country. Each bill provides for the allocation of funds by the Federal Government to assist the medical schools in maintaining and expanding their present educational programs. There are a good many reasons for being concerned about the participation of the Federal Government in the financing of medical education. It means a further intrusion by the Federal power into another field of private activity. It means another charge against the Federal Treasury when some in the Government are urging economy and others an increase in the tax rate. Whatever our views as citizens may be, we shall limit our discussion today to the effect of this proposed new assumption of Federal responsibility on medical education and medical care. Dr. Weiskotten will comment on the specific provisions of these bills. I would like at this time to discuss briefly the general problem of the financial support of medical education.

As already mentioned by Dr. Scheele, medical education is the most extensive type of professional training. For many years the American Medical Association through the Council on Medical Education and Hospitals has been urging that adequate financial support be provided the medical schools of the country so that they would have the staff and facilities to offer the highest type of training which modern science makes possible. Satisfactory medical education can be provided only by institutions that have sufficient funds to employ competent teachers and to build, equip, and maintain laboratories for teaching and research. Our knowledge of disease and its treatment, while still incomplete, has advanced to the point where only physicians who have had the benefit of a sound education in the fundamentals of medical science should be entrusted with the lives and health of our citizens.

The sums expended by the individual medical schools for the education of a single student vary from close to $1,000 to more than

$5,000 annually. No school can charge student fees that will meet the cost of maintaining such an expensive program of instruction. A recent study by the Council on Medical Education and Hospitals revealed that student fees provide only 25 percent of the total funds needed to operate our medical schools. The balance of the funds used in operating the medical schools is obtained from income on endowments, other university funds, gifts, and taxes.

There are at present seventy-two 4-year medical schools and 7 schools of the basic medical sciences in the United States. Of these institutions, 32 are State supported, 3 are municipal institutions, 1 institution is supported by the Federal Government, and 43 are private institutions. Of this latter group, the six medical schools in Pennsylvania receive substantial aid from State funds.

The medical schools have not been entirely unsuccessful in improving their financial condition in recent years. As evidence of the increase of maintenance of interest on the local level, it can be pointed out that the total of the budgets of all the medical schools in the country today is somewhat more than twice the amount that was expended by the medical schools 15 years ago. Despite this increase, practically all medical schools require additional funds if they are to make maximum use of their present facilities and if they are to offer educational programs that approach the ideal.

As might be expected, the need for such additional funds and the use to which they would be put vary widely from institution to institution. However, the major utilization of these funds can be classified under four general categories:

(1) The employment of additional instructors to provide more individual supervision and instruction;

(2) The raising of salaries of present faculty members to permit them to continue their careers as teachers;

(3) The renovation and modernization of laboratories and other facilities;

(4) The construction of new facilities.

An accurate estimate of the total amount of additional money needed by the medical schools can be computed only after each school has made a detailed study of its needs. Some schools have already carried out such studies; others have attempted to estimate their financial needs in general terms.

The Survey of Medical Education sponsored by the American Medical Association and the Association of American Medical Colleges was initiated early this year, and will extend over the next 3 years. One of the objectives of the survey will be to stimulate schools to make precise estimates of the funds that they need to complete the development of their present program and estimate the funds required for the maximum expansion of their facilities consistent with efficient operation.

An inquiry conducted last summer by the council revealed that for the fiscal year ending June 30, 1949, the budgets of the medical schools totaled approximately $51,000,000. At the same time the schools reported that they estimated their need for additional funds for operating purposes at between $10,000,000 and $15,000,000 a year.

The figures just quoted represent funds that the schools require to stabilize and perfect their present programs. They might make possible some expansion, but that is not what they are primarily needed for.

I would like to emphasize a point that will doubtless be made by a majority of the educators, if not all, who appear before this committee. If the quality of medical attention is to be preserved, the schools must be provided with sufficient funds to correct deficiencies in their present programs before they undertake to train an increased number of students. Without such assistance, straining their present inadequate staffs and facilities in an effort to train more students will result in a deterioration in the quality of medical education and ultimately of medical care. Any legislation providing Federal assistance to the medical schools should first allocate sufficient funds to the schools to bring their present programs up to higher standards. Funds to stimulate expansion should be provided only after the need for maintenance has been adequately met.

While there are many indications that the country could use more physicians, the insufficiency of our present production of physicians has been exaggerated in many quarters. I would like to state that we feel that there is a real need for a thorough, careful study of this problem. We have enjoyed gazing into the crystal ball with Mr. Perrot on a number of occasions, but it is very difficult in a limited type of statistical study to come out with an accurate estimate.

I would like to point out also that a shortage of 15,000 physicians would represent a shortage of about 7.5 percent of the total physician body that we will have in 1960, and I would like to point out that during the war years 40 percent of our physicians were in the armed services, taking care of about 9 percent of our population; only 60 percent of our physicians were left to take care of 91 percent of our population, and yet the Nation's health continued to improve.

Now, those were not ideal conditions, and we certainly would not want to recommend them. This experience does bring out however, capacity of the medical profession to respond to variations in demand for medical services that would not show up in simple counting of individuals.

For the past 20 years the physician population of the United States has been increasing at a relatively more rapid rate than has the general population, and this holds true even for the period of the bumper baby crops. Since 1940 the population has increased 12 percent, and the physician population has increased 14 percent. As a result, this country today has more physicians per unit of population than any other country except Israel, where a large number of physicians have located as displaced persons.

All indications are that this trend will continue. In the past 7 years six new medical schools have been established. Several States now have under consideration the establishment of additional schools. A number of the existing schools have secured increased financial support that will enable them to increase their facilities and to accept additional students in the immediate future.

Official statistics on the total enrollment in the freshman class in the medical schools this coming fall will not be available for several weeks. On the basis of partial and informal reports, it would appear likely that this class will be 5 to 10 percent larger than similar classes in the past. This increase represents the annual output of graduates of at least six new medical schools.

In evaluating the question of physician shortage, we must recognize that approximately 5,000 physicians who graduated from medical school just before or during the war and who in the normal course of events would by this time have finished their graduate training and entered practice are still completing their residency training which was interrupted by the war. When the majority of these physicians leave their hospital positions within the next year or two to enter practice, many communities now faced with a shortage of physicians will experience definite relief.

In many respects the problem of the supply of physicians is more specifically a problem of distribution, rather than of the over-all number. Increasing the number of physicians graduated annually would not of itself reverse the trend for physicians to settle in urban areas. This trend has been most marked during the past 20 years, a period when the supply of physicians has actually been increasing. This trend must be combated by specific measures to increase the attractiveness of practice in rural areas, such as the Hill-Burton Act as well as local community effort to provide conditions that will attract physicians.

The high quality of medical care enjoyed by the people of the United States today is basically the result of the improvements in medical education that have taken place in this country during the past 40 years. Two well-trained physicians have a greater potential for rendering effective medical care than do three inadequately trained physicians. To dilute the quality of medical education by urging or inducing the medical schools to increase rapidly the volume of students beyond the capacity of the schools to offer a satisfactory quality of medical education would, in the long run, defeat the objectives of a program initiated for the specific purpose of improving the health of the American people.

While additional funds could be put to good use by all medical schools and are urgently needed by some, all medical educators are agreed that the sacrifice of academic freedom would be too high a price to pay for such funds. Although many improvements are possible in medical education, the standards of medical education in the United States today are still very high. Furthermore, medical education is in safe hands. No other professional group has assumed responsibility more effectively in the education of its members than have the physicians of our Nation. Medical educators have emphatically indicated that they do not wish Federal support, if Federal officials are to be empowered to regulate, directly or indirectly, the curriculum, the administration, or the admission policies of the medical schools.

I would like to have Dr. Weiskotten continue our presentation, with your permission.

Mr. Priest. May the Chair inquire if Dr. Anderson will resume at any other point? If not, it may be that there are some questions at the end of your part of the testimony that members of the committee will want to ask.

Dr. Anderson. I shall not be resuming.

Mr. Priest. Are there questions at this point that you would like to ask of Dr. Anderson?

Mr. Sadowski. Just in regard to the last statement that the Doctor made, that the medical educators have emphatically indicated that they do not wish Federal support if Federal officials are to be empowered to regulate directly or indirectly the policies or curriculum and administration.

Why should there be such terrific objection to that, when on page 4 of your statement you say that out of the 72 4-year medical schools and the 7 schools of the basic medical sciences in the United States there are only 43 that are private institutions and 6 of these are receiving substantial State funds?

It would seem to me that over one-half of the schools now are State-controlled or State-dominated, and you do have a certain amount of bureaucratic regulation there.

What would be the objection to having Federal supervision and regulations, if Federal money is given to aid these schools?

Dr. ANDERSON. Dr. Weiskotten is going to elaborate on that point.

The main thing we have in mind is that Federal control would centralize in one place control of all of the medical schools whereas at present it is on a local level, even though many of the schools are State-supported. I think that you will find Dr. Weiskotten bringing out more specifically and clearly what we have in mind.

Mr. SADOWSKI. The college of medicine at the University of Michigan, for instance, is subject to certain State controls, also, I believe, are they not? That is not a private school of medicine, is it?

Dr. WEISKOTTEN. Michigan is a State-supported school.

Mr. SADOWSKI. I have not heard any objection from the medical people in the State of Michigan toward this question, or against State bureaucratic control of that school.

Dr. ANDERSON. We are not making the distinction between private and State control, we are making the distinction between local and centralized control. At the University of Michigan I believe they have a board of trustees which really takes direct responsibility for the operation of the medical school.

Mr. SADOWSKI. They have regents that are elected, of course, by the people, so definitely it is a political set-up and no one complains about it.

Dr. ANDERSON. As I say, our distinction is not between private and Government control, but between local and centralized control.

Mr. PRIEST. Are there any other questions?

Mr. BIEMILLER. I have one or two purely factual questions that I would like to raise.

Doctor, you spoke of students transferring from the seven schools in the basic sciences to the seventy-two 4-year schools. Do they have any difficulty getting into the 4-year schools? Are the 4-year schools pretty crowded?

Dr. ANDERSON. That is true. Particularly in recent years. Up to the last 2 or 3 years that has not been true. At present with the 4-year schools straining to take every student they can accommodate and with a better class of students coming along, there are fewer vacancies in the third- and fourth-year classes. The 4-year schools now start with larger student bodies and they have fewer failures, so that they have fewer vacancies in the third and fourth years. Then the 2-year schools have also been taking more students and better students, so that they actually have more students to place at the end of the 2 years than they had formerly.

As a result, some of them are having a difficult time.

Mr. BIEMILLER. It is at least theoretically possible that these basic schools may eventually just not be able to do anything with their people; is that true?

Dr. ANDERSON. Theoretically, yes, but many of them are trying to develop into 4-year schools. That is the general pattern.

Mr. BIEMILLER. You anticipate my next question. I was wondering whether there was a tendency for that to develop?

Dr. ANDERSON. All but one school has either now under active consideration or has had under consideration during the last year or two, plans for becoming a 4-year school.

Mr. BIEMILLER. I would assume that that would be a perfectly good, healthy development of the kind the council would encourage.

Dr. ANDERSON. Very definitely.

Mr. BIEMILLER. Secondly, on page 4 you speak of the question of raising salaries of present faculty members to permit them to continue their careers as teachers.

Will that data that you will supply us have any break-down as to the number of faculty members who are full-time and the number who are part-time, and also engage in private practice?

Dr. ANDERSON. It will not. That type of survey has not been made for several years. It happens by coincidence, we are making such a survey this year so that in our next educational number in September, we will have that data.

Mr. BIEMILLER. I was talking to a Member of the Congress yesterday whom I think it best not to identfy, because I did not ask him if I could use that information, who happens to be a trustee of a medical school, and he reports that a large number of their faculty are also engaged in private practice.

Usually the faculty members are very first-rate people if they are in private practice also, and do command probably as high fees as anyone in the profession would.

This particular trustee reports that there is a good deal of jealousy developing between not only the full-time faculty member of the medical school, but even more so the full-time faculty member of a law school or a liberal arts school who is always full-time, between that person and the part-time teacher who is also engaging in private practice.

Now, is that a general problem that you have been encountering around the country?

Dr. ANDERSON. The problem is very complex, Mr. Biemiller. In the first place, every medical school today has to have a corps of full-time teachers who do not practice, to carry on their educational programs. Their work is supplemented by teachers who volunteer their services and earn their living practicing medicine. That helps to keep the cost of medical education down. If those men had to be paid, our costs would be even greater.

In the preclinical or basic science departments of anatomy, and bacteriology and physiology and chemistry that is the strictly laboratory sciences, the salaries through the country by and large have been very low. They vary, of course, from school to school, but tend to be low. One of the reasons we are having difficulty in expanding is the difficulty in securing teachers in these fields. Not many men are interested either in studying these subjects or serving as teachers in those fields. Even in the clinical fields, where we have full-time instructors, the great majority of those men get salaries that are only a fraction, possibly a third, of what they would make if they were in private practice. There is a difference, as you have pointed out, between the salaries in the medical schools and the salaries in other departments, particularly undergraduate departments of the universities. That has developed over the years, and I imagine it will probably continue to develop.

Medical schools, in order to get capable men who could go out and earn a modest living in practice, have to at least give them a modest wage, whereas in the graduate school many of the teachers do not have many opportunities for another type of work.

I think that that has been a factor in the differential you mention.

Mr. Biemiller. I am quite aware of the complication that exists, but I was wondering how serious the problem might be.

I have just one more question, because most of the others, I think, had better be saved until Dr. Weiskotten finishes.

I want to revert for a moment to these seven schools. It is rather obvious—and waiving for a moment any objections that may appear to any other parts of the bill—that if the bill in substantially the form it is now were passed, in terms of grants to medical schools, it might stimulate these six or seven basic science schools into expanding their courses, because they would benefit in one sense more than any other place in the country; would they not?

Dr. Anderson. I think that that is very likely.

Mr. Biemiller. In that sense, it might have an immediate good effect, that it might help expand those six schools, if nothing else, into a more rapid development, waiving for the moment certain obvious questions.

Dr. Anderson. It would be immediate in terms of several years. Those schools would have to acquire staffs and hospital facilities first.

Mr. Biemiller. I do not mean in the sense of a year. I am quite aware of that.

Mr. Wilson. Dr. Anderson, going further into the question that was asked by Congressman Sadowski, your reasons for objecting to Federal control or Federal supervision or central administration at the Federal level are set out here. You say that the schools have emphatically indicated they do not wish Federal support if these things are attached to it.

Then I suppose that you are referring to what you said earlier in your statement, speaking of these seventy-two 4-year medical schools, where you say 32 of these institutions are State-supported, 3 are municipal institutions, and 1 institution is supported by the Federal Government. You say 43 are private institutions.

What is the one presently supported by the Government?

Dr. Anderson. That is Howard University.

Mr. Wilson. Will you supply the names of these 72 schools for the record?

Dr. Anderson. Yes; they are in this pamphlet which I have for presentation to the chairman.

Mr. Wilson. Mr. Chairman, will that be included in the record?

Mr. Priest. It will be included, and copies will be furnished to members of the subcommittee also.

(The information is as follows:)

TABLE 2.—*Approved medical schools in the United States*

Name and location of school	1949 premedical requirement by years	Students by classes, 1947–48						Graduates July 1, 1947, to June 30, 1948	Executive officer
		Freshman	Sophomore	Junior	Senior	Required intern year	Totals [1]		
ALABAMA									
1 Medical College of Alabama, Birmingham [2]	3	52	48	32	[3] 0	--------	132	(3)	Roy R. Kracke, M. D., dean.
ARKANSAS									
2 University of Arkansas School of Medicine, Little Rock [2]	3	91	74	54	55	--------	274	55	Joseph T. Roberts, Md. D., dean.
CALIFORNIA									
3 University of California Medical School, Berkeley-San Francisco.[2]	3	72	72	71	68	--------	283	68	Francis Scott Smyth, M. D., dean.
4 College of Medical Evangelists, Loma Linda-Los Angeles.	3	79	81	74	85	88	319	87	Harold Shryock, M. D., dean, Loma Linda; W. F. Norwood, Ph. D., dean, Los Angeles.
5 University of Southern California School of Medicine, Los Angeles.	3	67	63	61	60	58	251	58	Burrell O. Raulston, M. D., dean.
6 Stanford University School of Medicine, Stanford University-San Francisco.	3	63	59	60	60	57	242	57	Loren R. Chandler, M. D., dean, San Francisco.
COLORADO									
7 University of Colorado School of Medicine, Denver [2]	(4)	60	62	59	52	--------	233	52	Ward Darley, M. D., dean.
CONNECTICUT									
8 Yale University School of Medicine, New Haven	3	60	55	49	58	--------	222	55	C. N. Hugh Long, M. D., dean.
DISTRICT OF COLUMBIA									
9 Georgetown University School of Medicine, Washington	(5)	120	92	79	78	--------	369	75	Paul A. McNally, S. J., Ph. D., dean.
10 George Washington University School of Medicine, Washington.	3	88	77	70	80	--------	315	80	Walter A. Bloedorn, M. D., dean.
11 Howard University College of Medicine, Washington [6]	2	75	65	68	66	--------	274	64	Joseph L. Johnson, M. D., dean.
GEORGIA									
12 University of Georgia School of Medicine, Augusta [2]	3	77	79	68	66	--------	290	66	G. Lombard Kelly, M. D., dean.
13 Emory University School of Medicine, Emory University	3	65	59	38	48	--------	210	48	R. Hugh Wood, M. D., dean.

See footnotes at end of table.

TABLE 2.—*Approved medical schools in the United States*—Continued

Name and location of school	1949 premedical requirement by years	Students by classes, 1947–48						Graduates July 1, 1947, to June 30, 1948	Executive officer
		Freshman	Sophomore	Junior	Senior	Required intern year	Totals[1]		
ILLINOIS									
14 Northwestern University Medical School, Chicago	(7)	127	124	136	133	143	520	143	J. Roscoe Miller, M. D., dean.
15 Stritch School of Medicine of Loyola University, Chicago.	(4)	88	67	55	67	--------	277	67	James J. Smith, M. D., dean.
16 University of Chicago, the School of Medicine	3	64	61	56	51	--------	232	51	A. C. Bachmeyer, M. D., associate dean, biology division; F. J. Mullin, Ph. D., dean of students.
17 University of Illinois College of Medicine, Chicago[2]	3	167	156	163	148	--------	634	147	John B. Youmans, M. D., dean.
INDIANA									
18 Indiana University School of Medicine, Bloomington-Indianapolis.[2]	3	130	101	80	85	--------	396	84	John D. VanNuys, M. D., dean, Indianapolis.
IOWA									
19 State University of Iowa College of Medicine, Iowa City.[2]	3	90	70	61	57	--------	278	57	Mayo H. Soley, M. D., dean.
KANSAS									
20 University of Kansas School of Medicine, Lawrence-Kansas City.[2]	3	84	85	83	56	--------	308	56	Franklin D. Murphy, M. D., dean, Kansas City.
KENTUCKY									
21 University of Louisville School of Medicine, Louisville[8]	2	96	83	86	60	--------	325	[10] 144	John Walker Moore, M. D., dean.
LOUISIANA									
22 Louisiana State University School of Medicine, New Orleans.[2]	(4)	100	71	57	80	--------	308	80	Vernon W. Lippard, M. D., dean.
23 Tulane University of Louisiana School of Medicine, New Orleans.	3	143	120	115	99	--------	477	97	Maxwell E. Lapham, M. D., dean.
MARYLAND									
24 Johns Hopkins University School of Medicine, Baltimore.	(5)	73	73	72	79	--------	297	78	Alan M. Chesney, M. D., dean.
25 University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore.[2]	3	96	79	69	78	--------	322	77	H. Boyd Wylie, M. D., dean.

	MASSACHUSETTS									
26	Boston University School of Medicine, Boston	3	70	56	54	55	--------	235	54	James M. Faulkner, M. D., dean.
27	Harvard Medical School, Boston	2	111	109	144	140	--------	504	140	C. Sidney Burwell, M. D., dean.
28	Tufts College Medical School, Boston	(9)	112	98	86	98	--------	394	94	Dwight O'Hara, M. D., dean.
	MICHIGAN									
29	University of Michigan Medical School, Ann Arbor [2]	3	130	105	109	132	--------	476	132	Albert C. Furstenberg, M. D., dean.
30	Wayne University College of Medicine, Detroit [8]	3	68	60	37	61	--------	226	60	Hardy A. Kemp, M. D., dean.
	MINNESOTA									
31	University of Minnesota Medical School, Minneapolis [2]	3	123	101	92	75	101	391	[10] 140	Harold S. Diehl, M. D., dean.
	MISSOURI									
32	St. Louis University School of Medicine, St. Louis	3	115	106	91	120	--------	432	120	Alphonse M. Schwitalla, S. J., Ph. D., dean.
33	Washington University School of Medicine, St. Louis	3	86	82	101	91	--------	360	90	Robert A. Moore, M. D., dean.
	NEBRASKA									
34	Creighton University School of Medicine, Omaha	3	75	62	42	65	--------	244	65	Percy J. Carroll, M. D., dean.
35	University of Nebraska College of Medicine, Omaha [2]	3	89	78	59	67	--------	293	67	Harold C. Lueth, M. D., dean.
	NEW YORK									
36	Albany Medical College, Albany	3	48	51	42	41	--------	182	40	R. S. Cunningham, M. D., dean.
37	Long Island College of Medicine, Brooklyn	3	113	98	101	92	--------	404	92	Jean A. Curran, M. D., president; Duncan W. Clark, M. D., dean.
38	University of Buffalo School of Medicine, Buffalo	3	71	71	56	75	--------	273	74	Stockton Kimball, M. D., dean.
39	Columbia University College of Physicians and Surgeons, New York.	3	114	106	110	102	--------	432	100	Willard C. Rappleye, M. D., dean.
40	Cornell University Medical College, New York	3	85	79	73	78	--------	315	78	Joseph C. Hinsey, Ph. D., dean.
41	New York Medical College, Flower and Fifth Avenue Hospitals, New York.	3	124	107	96	119	--------	446	119	J. A. W. Hetrick, M. D., president and dean.
42	New York University College of Medicine, New York	3	127	115	113	132	--------	487	132	Currier McEwen, M. D., dean.
43	University of Rochester School of Medicine and Dentistry, Rochester.	3	68	65	68	66	--------	267	66	George H. Whipple, M. D., dean.
44	Syracuse University College of Medicine, Syracuse	3	56	46	46	42	--------	190	41	H. G. Weiskotten, M. D., dean.
	NORTH CAROLINA									
45	Duke University School of Medicine, Durham	3	73	69	62	66	--------	270	66	Wilburt C. Davison, M. D., dean.
46	Bowman Gray School of Medicine of Wake Forest College, Winston-Salem.	3	54	41	40	49	--------	184	48	C. C. Carpenter, M. D., dean.

See footnotes at end of table.

TABLE 2.—*Approved medical schools in the United States*—Continued

Name and location of school	1949 premedical requirement by years	Students by classes, 1947–48						Graduates July 1, 1947, to June 30, 1948	Executive officer
		Freshman	Sophomore	Junior	Senior	Required intern year	Totals[1]		
OHIO									
47 University of Cincinnati College of Medicine, Cincinnati.[8]		87	77	81	76	--------	321	76	Stanley Dorst, M. D., dean.
48 Western Reserve University School of Medicine, Cleveland.	3	78	79	78	77	--------	312	77	Joseph T. Wearn, M. D., dean.
49 Ohio State University College of Medicine, Columbus[2]	3	85	75	85	72	--------	317	72	Charles A. Doan, M. D., dean.
OKLAHOMA									
50 University of Oklahoma School of Medicine, Oklahoma City.[2]	3	66	75	56	62	--------	259	62	Mark R. Everett, Ph. D., dean.
OREGON									
51 University of Oregon Medical School, Portland[2]	3	78	65	59	68	--------	270	65	D. W. E. Baird, M. D., dean.
PENNSYLVANIA									
52 Hahnemann Medical College and Hospital of Philadelphia.[11]	3	105	88	98	114	--------	405	112	Charles L. Brown, M. D., dean.
53 Jefferson Medical College of Philadelphia	3	166	152	151	152	--------	621	148	William H. Perkins, M. D., dean.
54 Temple University School of Medicine, Philadelphia	3	133	103	99	124	--------	459	124	William N. Parkinson, M. D., dean.
55 University of Pennsylvania School of Medicine, Philadelphia.	3	119	106	125	129	--------	479	127	John McK. Mitchell, M. D., dean.
56 Woman's Medical College of Pennsylvania, Philadelphia	3	50	42	31	35	--------	158	35	Marion Fay, Ph. D., dean.
57 University of Pittsburgh School of Medicine, Pittsburgh	2	86	73	69	75	--------	303	75	William S. McEllroy, M. D., dean.
SOUTH CAROLINA									
58 Medical College of the State of South Carolina, Charleston.[2]	3	60	57	42	53	--------	212	53	Kenneth M. Lynch, M. D., dean.
TENNESSEE									
59 University of Tennessee College of Medicine, Memphis[2]	2	157	140	115	90	--------	511	99	O. W. Hyman, Ph. D., dean.
60 Meharry Medical College, Nashville	2	67	65	44	58	--------	234	58	Murray C. Brown, M. D., director of medical education; Michael J. Bent, M. D., dean.
61 Vanderbilt University School of Medicine, Nashville	(5)	53	49	51	54	--------	207	54	Ernest W. Goodpasture, M. D., dean.

	TEXAS									
62	Southwestern Medical College, Dallas	3	61	54	58	51		224	50	W. Lee Hart, M. D., dean.
63	University of Texas School of Medicine, Galveston [2]	3	108	90	69	80		347	80	Chauncey D. Leake, Ph. D., vice president; D. Bailey Calvin, Ph. D., dean of student and curricular affairs.
64	Baylor University College of Medicine, Houston	3	92	72	65	64		293	64	W. H. Moursund, M. D., dean.
	UTAH									
65	University of Utah School of Medicine, Salt Lake City [2]	3	50	51	40	37		178	36	Richard H. Young, M. D., dean.
	VERMONT									
66	University of Vermont College of Medicine, Burlington [2]	3	41	35	35	42		153	40	William Eustis Brown, M. D., dean.
	VIRGINIA									
67	University of Virginia Department of Medicine, Charlottesville.[2]	3	72	59	59	60		250	59	Harvey E. Jordan, Ph. D., dean.
68	Medical College of Virginia, Richmond [2]	3	84	77	71	82		314	85	Harvey B. Haag, M. D., dean.
	WISCONSIN									
69	University of Wisconsin Medical School, Madison [2]	3	76	83	60	59		278	59	William S. Middleton, M. D., dean.
70	Marquette University School of Medicine, Milwaukee	3	100	93	75	82		350	[10] 169	John S. Hirschboeck, M. D., dean.
	Total		6, 213	5, 541	5, 154	5, 340	[11] 447	22, 248	5, 543	

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[1] On probation.
[2] State-supported.
[3] No seniors or graduates due to deceleration.
[4] 90 semester-hours.
[5] Degree; 90 semester-hours for veterans.
[6] Federally supported.
[7] 85 semester-hours.
[8] Municipally supported.
[9] 4 and degree.
[10] Figures are for two graduating classes and include senior students reported in 1947 Educational Number.
[11] Intern enrollment not included in total column.

Mr. WILSON. I was interested in what you said earlier in your statement:

> While there are many indications that the country could use more physicians, the insufficiency of our present production of physicians has been exaggerated in many quarters. For the past 20 years our physician population of the United States has been increasing at a relatively more rapid rate than that of the general population.

You interpolated, I believe, from your prepared statement, and you used the percentages, the comparison of 12 percent and 14 percent. Is that of the past year or over the 20-year period, and can you develop that a little more? I think my mind will be disabused a bit if that is the case.

Dr. ANDERSON. The specific figures of 12 and 14 percent refer to the period 1940 up to the present, the last 8½ years. In 1929—I have not the figure right at the tip of my tongue—there was approximately 1 physician for every 800 persons in the United States, and at the present time there is 1 physician for every 730 persons in the United States. Those figures are subject to slight changes in the last decimal place, but that is the order of increase.

Mr. WILSON. Say that again, please?

Dr. ANDERSON. In 1929 there was 1 physician for approximately every 800 persons, and at present there is 1 physician for approximately every 730 persons in the country.

Mr. BIEMILLER. Are you speaking now of physicians in terms of graduate physicians, or practicing physicians?

Dr. ANDERSON. That is the total number of living physicians licensed to practice.

Mr. BIEMILLER. That would then include those who, because of age, have either retired or are simply doing part-time work?

Dr. ANDERSON. That is right. Accurate figures as to the number retired are not available from any source, and we have to assume that the proportion of those retired in 1929 is about the same as the proportion now.

Mr. WILSON. I believe that one of the preceding witnesses on the stand, I think the Surgeon General, made reference to that.

Could you furnish an analysis or break-down showing what number of applicants there were and the number of graduates of the various medical schools throughout the past several years? I am wondering if that is to be included in the proposed analysis to be presented. If not, I would like to have it.

Dr. ANDERSON. The graduates are included in our statistics. Studies relating to admissions, the number of applicants, and the number accepted have been conducted for many years by the Association of American Medical Colleges, and we have not duplicated that work. I am quite sure that they will be prepared to give you the full report of their study.

Mr. WILSON. If that is to be included in the record by someone else, we will wait on that.

Mr. PRIEST. We have a representative from the Association of Medical Colleges, and he will probably be able to supply that information.

Mr. WILSON. Thank you.

Mr. PRIEST. Then, if there are no further questions of Dr. Anderson, we will proceed.

Mr. SADOWSKI. I would like to ask this question. You made reference to some 5,000 medical students that have attended school during the war and immediately after, and that this large group will supplement our present medical field of doctors.

Do you know, Doctor, how many medical students actually received Federal aid and assistance during the war and immediately thereafter?

Dr. ANDERSON. I would have to estimate that. I am sure that that information is available, but I would have to estimate it.

I think that during the period of the war there were approximately 20,000 to 24,000 students who received all or part of their medical education under the AST or the V–12 programs.

Mr. SADOWSKI. What would be the ratio of those students as against the other students who received no Federal aid?

Dr. ANDERSON. During the war, I think about 75 percent of the students were receiving Federal aid.

Mr. SADOWSKI. That Federal aid must have proven of great value to the colleges and universities.

Dr. ANDERSON. It did not assist them at all, sir, because these were enlisted men in the Army and Navy. The Army and Navy merely paid the regular tuition fees. They did not give any direct support to the medical school. They paid the tuition fee that the boy would have paid as a private student, so it did not increase the support. The Army and Navy did not pay cost.

Mr. SADOWSKI. They did not increase the revenues of the schools as such.

Dr. ANDERSON. That is right.

Mr. PRIEST. Dr. Weiskotten, you may proceed.

Dr. WEISKOTTEN. The unknown implications and consequences of Federal aid are a cause for concern. It is clearly recognized that the Federal Government has a definite responsibility to supervise the spending of public money. Many question whether such supervision can be accomplished without opening the door to Federal control of many important activities of the medical schools.

It may be maintained that the Federal Government has for many years contributed to the support of the land-grant colleges without interfering with the policies of those institutions. Furthermore, the Federal Government has supported scientific research in recent years without interfering with the freedom of the individual research worker. There is a question, however, whether the experience with Federal support in these areas can be accepted as defining the pattern which will be followed in dealing with the educational program of the medical schools.

Medical education is intimately related to medical care, which promises to be the subject of intense political discussion for some time to come. It is conceivable, therefore, that if the Federal Government should acquire the power to supervise the medical schools, the conduct of medical education might be subjected to adverse regulation in an attempt to alter the Nation's over-all program for providing medical service.

Much of the concern about Federal aid to medical education would be removed if the basic legislation providing such aid could be written so that no Federal official, through the promulgation of regulations, could exercise direct or indirect control over the activities of the medical schools. No Federal official, nor anybody created by him, should have the power to determine academic standards or to decide which schools should be eligible for Federal aid. Otherwise the control of medical education would inevitably and unmistakably be centralized in Washington. It is imperative that the supervision of academic standards be kept in the hands of the medical schools, the profession and the States. This objective could be achieved if the basic legislation contained a declaration that any medical school shall be eligible for financial aid of three-fourths of the States, through their medical licensing authorities, judge the school to be of sufficiently high quality to admit its graduates to the State examinations for medical licensure.

Another concern about Federal aid to medical education relates to the effect that it will have on local support of medical schools from both private and public funds. To prevent any possibility that the Federal Government may eventually be required to assume the full responsibility for medical education, Federal funds should not be made available to a degree that will diminish local responsibility for the support and establishment of medical schools. It is suggested, therefore, that no matter what formula is used for determining the amount of Federal aid provided, the total sum provided any individual school should in no case constitute more than 30 percent of the school's total budget.

The question of providing Federal assistance for construction would appear to be a complex one. Many schools need funds for modernizing and renovating their existing buildings more urgently than they do for new construction. To promote the most economical use of funds and to make certain that no school is denied assistance that it needs, any provision for funds for construction should recognize this circumstance. It is difficult to see how a satisfactory objective formula for furnishing funds for construction can be developed.

On the subject of scholarships, all medical educators are agreed that there should be adequate scholarship aid available to those young people who offer real promise but who are financially unable to undertake a program of medical education. Many medical educators, however, are opposed to establishing the requirement that in return for such scholarship aid, a student must agree to practice medicine in a designated area or to serve with a Federal agency for a given period of time after completion of his medical education. Such proposals represent a regimentation of the students, which is entirely unjustifiable.

At the time a student is admitted to a medical school, no one can foretell what his interests and potentialities will be upon the completion of his medical course. To force a potentially great teacher, administrator, or research worker to discontinue his training and serve several years in rural practice or in Federal service is a disservice to humanity. The first few years after graduation from medical school are undoubtedly the most important years of a physician's career. To regiment a student for these years before he has even initiated his medical studies would appear to be both unwise and unfair to the student. One of our large philanthropic foundations has experimented with such a program and found it to be unsatisfactory and unsuccessful.

As a question of sound academic practice, under any scholarship program the selection and supervision of the students receiving aid must be vested in the school responsible for their education.

I would like now to comment on the specific provisions for the support of medical education contained in H. R. 4312 and H. R. 4313. It is my understanding that these bills have superseded H. R. 3894, so that I shall limit my comments to the former bills.

These bills place disproportionate emphasis on assisting the schools to increase their enrollments and insufficient emphasis on aiding the schools to strengthen and improve their present programs. This is clearly reflected in the formula set forth for calculating the payments to the schools for the cost of instruction. This formula—top of page 13—provides that a medical school will receive $300 for each student enrolled up to its average past enrollment, and $1,700 for each student enrolled in excess of its average past enrollment. Under a further provision of this bill—page 15, lines 6 to 20—new medical schools would be greatly favored over existing medical schools since new schools would receive $850 for every student they enrolled.

The wide spread between the $300 to be paid for each student up to the average past enrollment and the $1,700 to be paid for each additional student penalizes severely those schools that have in the past few years secured local support which has permitted them to increase their enrollments. The wisdom of this formula may also be questioned on the grounds that it offers a financial premium which might induce certain schools to enroll more students than they can properly accommodate.

The bill provides that payments to the schools for costs of instruction shall not exceed 50 percent of the amount determined to be the instructional budget in any school for any given year. As I have already indicated, a ceiling of this type is highly desirable, but in the interest of maintaining local support and responsibility, it would appear advisable to set the ceiling at 30 percent instead of 50 percent.

The section providing for grants for construction and equipment requires that the Surgeon General consult with the National Council on Education for Health Professions before making grants, but leaves entirely to the discretion of the Surgeon General the actual awarding of such grants—page 17, lines 14 to 19. This provision is especially dangerous. It would expose the Surgeon General to undue pressures and it vests in one man the power to decide for the entire country where additional construction needs are most urgent.

Under the section on conditions for grants—page 19, lines 13 to 15—it is required that the school give adequate assurance that it does not and will not impose any unreasonable restriction against the admission of out-of-State students. The statement "unreasonable restrictions" is vague and would appear to permit the Surgeon General to influence the admission policies of a school by the interpretation he chose to place on this phrase.

The section on conditions for awarding of scholarships—page 28, lines 4 to 23—require an appointee to agree upon completion of his training to practice in an area designated by his State agency or in a medical agency or unit of the United States, giving 1 year for every 2 academic years during which he received the benefits of a scholarship. I have already pointed out that such provisions constitute unwise and unjustified regimentation of youth.

The section on regulations—page 30, lines 18 to 22—does not specify who will make the regulations, but implies that they will be made by a Federal official who must consult, but who will not be bound by, the National Council on Education for Health Professions. Accordingly, full authority for establishing regulations which directly and indirectly may limit the academic freedom of the schools will be vested in the hands of one individual.

The bill, on page 31, provides for the creation of a National Council on Education for Health Professions. It is, of course, highly desirable that any Federal official who administers a program of Federal aid to medical education should have an advisory council. This council should be given more authority than that assigned to a consultative body and should have broad representation from the field of medical education. As presently proposed, at the top of page 32, the council would have 10 members representing 5 fields of professional education. Presumably, this would permit only two representatives of medical education. This appears to be a further concentration of power in the hands of a few individuals. Any activity as complex as medical education should have at least five representatives at the top policy-making or advisory level.

I should like to summarize my testimony by saying that there are many reasons for hoping that Federal aid for the support of medical education may not be necessary. Should it be decided that Federal support is the only means of preventing a grave impairment of both the quality and the extent of the facilities available in this country for medical education, it is to be hoped that the basic legislation providing such aid will contain adequate and unmistakable safeguards. These safeguards should insure the preservation of academic freedom and protect the medical schools from political or governmental interference in planning their curricula, in establishing administrative policies and in the selection of students. This can best be accomplished by establishing objective formulas, in the basic legislation, for the payments to the medical schools. The basic legislation should also limit the responsibility and authority of the officials administering the act to an audit which will determine that the funds are being used for the general purposes for which they were granted.

The formulas that are adopted for computing the payments to the schools should reflect the fact that Federal aid to medical education will be most effective in improving the Nation's health and medical care if such support is directed to stabilizing and improving our present programs of medical education.

Continuance of local responsibility for the support of educational institutions should be assured by limiting to approximately 30 percent the contribution of the Federal Government to the expense of any one institution.

In the desirable attempt to prevent the exclusion of students on the grounds of discrimination based on race, creed, color, national origin, or place of residence, care must be taken that standards for admission based on adequate collegiate preparation, character, intellectual ability, physical fitness, and personality suitability are not lowered.

Any program for scholarship aid must contain no provisions that will in effect regiment youth. The administration of such a program must rest in the hands of the schools responsible for the education of the recipients.

The medical schools of this country, under the guidance of competent medical educators, have served the people well for many years. They have given the United States the largest number of physicians and the best-trained physicians of any country in the world. The preservation of their independence and freedom is basic and essential to any program for improving the health and medical welfare of the American people. It is hoped that the Congress will recognize and respect this principle in enacting any legislation that may bear on the field of medical education.

Only if the weight of the evidence presented to your committee during these hearings definitely indicates that Federal financial support of medical education is imperative, and only if legislation consistent with the principles that we have outlined and containing the safeguards that we have mentioned can be enacted, would the American Medical Association be willing to endorse a trial of Federal aid to medical education.

Mr. Priest. Thank you, Dr. Weiskotten.

You cited several provisions of the bill which, in your opinion, confer too much authority on one individual, and other provisions with which you disagree.

I wonder if sometime in the near future someone representing the association might supply the committee with suggested amendments in those particulars which you cite? Would you be able to do that?

Dr. Weiskotten. Yes; I think that that might be possible.

Mr. Priest. Your suggestions as to what you think the language should be. The committee would be very happy to receive those suggestions when we go into executive session on the bill.

Dr. Weiskotten. We are not entirely sure the Federal aid to medical education is necessary, and I think that there are several reasons for questioning as to whether or not it is imperative, the main reason being that there probably has never been any Nation-wide fund raising attempted for the medical schools of the country.

Mr. Priest. The question in my mind, and one that is imperative, is that some assistance is greatly needed. Now, whether that assistance can be supplied from some other source is, I suppose, the question that you have in your mind. I have made a personal investigation on my own that convinces me without any doubt that some assistance is very greatly needed at this time. Now, as to where that assistance comes from, that is the question that you raise.

Dr. Weiskotten. There is no question about the need, Congressman Priest.

Mr. Sadowski. Dr. Weiskotten, you expressed yourself as being opposed to the regimentation of students, and I feel inclined to agree with you on that very, very much. On page 10 of your statement you say:

> To force a potentially great teacher, administrator, or research worker to discontinue his training and serve several years in rural practice or in Federal service is a disservice to humanity.

Further, you state the first few years after graduation are the most important years of a physician's career.

I understand that the Army has had some of its men in school and has paid for their education and training, and then after they graduate I understand that these young doctors are to put in at least 2 years of service in the Army. Is that correct, or am I wrong on that?

Dr. **Weiskotten.** Yes; that is right.

Mr. **Sadowski.** Are you in favor of that policy?

Dr. **Weiskotten.** That is after graduation, where a student has some knowledge as to what he would like to do. For example, the Army may offer the man an internship, and following the internship they may offer him a residency; that is, specialized training in some special field of medicine. So that while he is serving in the Army, he is really getting graduate training.

Now, that is somewhat different than taking a boy before he has entered medical school and offering him a scholarship, without knowing what his interests and potentialities will be, and then upon graduation requiring that man to go into Federal service or a rural area. The rural-area experiment was tried by one of the large foundations in this country, a private foundation, and it was abandoned after a number of years.

Mr. **Sadowski.** I agree with you that it is going to be most difficult to try to force any American citizen, whether he is a doctor or lawyer or whatever profession he may be in, to try to force him to serve in any particular community or any particular State. I think inducements will have to be made to attract professional men to come into those areas. I think that that is the way out.

Mr. **Biemiller.** Mr. Chairman, just to pick up there for a moment, and then I have one or two other points.

I take it, Doctor, you were referring, in the question of the military service, to the sort of thing which I witnessed in the Pacific, where young doctors who had been trained by the Government were out there in Navy and Army hospitals in the immediate postwar period, the year or two just after the war, and particularly in the Institute of Tropical Diseases. I gather those doctors were getting a very valuable experience of an internship, as you put it.

Dr. **Weiskotten.** Indeed they were.

Mr. **Biemiller.** If a scholarship student developed who had a particular interest in, let us say, cancer research—to get back to our peacetime conditions—and he was offered a scholarship for further work at the Cancer Institute, I assume that that is not at all the type of thing that you would object to. You would be for that sort of thing?

Dr. **Weiskotten.** Yes.

Mr. **Biemiller.** What you are thinking of is more specifically this rural problem, of trying to force people into that?

Dr. **Weiskotten.** I am thinking of the regimenting of a man's activities. Now, if he were especially interested in cancer and there was no opportunity for him to serve in the Federal Government in that field, then it would be just too bad to force that man into a Federal agency because he had had a scholarship.

Mr. **Biemiller.** Or force him to go over to the cut-over area of Wisconsin, which he might not have the slightest interest in going to.

Dr. **Wieskotten.** That is right.

Mr. **Biemiller.** I do not think that we would be very much apart on that. I think that we could work that out.

I also want to say, as our chairman suggested, I hope that you will bring in some concrete suggestions of changes in the bill, and I think, to alleviate any fear that you might have, the committee will not interpret your offer of those amendments as, hence, automatic endorsement of the bill. It is simply that we would appreciate getting the benefit of your suggestions, because I think, just speaking in generalities as you were, that there are not any great differences between us on most of these points. There are phrases that have to be worked out and I think that we can do that. But as one who has been an educator—and incidentally, 2 years were spent at your very estimable institution where I was on the faculty for 2 years teaching history—I am well aware of the fears that you have of the possibility of tight Federal control because of grants. Likewise, on the other hand, as one who has been in the Federal service, both in the executive end and legislative branches, I was pleased to note that you recognize that there has always got to be protection worked out, that the Federal Government just cannot say, "Here is money, do what you want with it."

That is a very ticklish problem that keeps coming up with almost every bill of this type that is before us. We have had it with the National Science Foundation, as you well know, Mr. Chairman, and almost every other bill, and I think that all of us are genuinely trying to find an honest solution to that question, where the taxpayer is protected and where the educator is equally protected. No one will work more zealously than I for academic freedom. I think it is needed, and I do not want someone dictating to the medical school what the curriculum would be. I think it would be a stupid procedure, and I hope and trust and think that we can work out the proper safeguards as we develop this legislation.

Dr. WEISKOTTEN. Our entire council and its staff will be very happy to be of every assistance possible.

Mr. BIEMILLER. I have one more point, and then I am through with my questions.

You touched very briefly on the discrimination question. I am sure I do not have to inform you that in recent years there have been a number of articles, some of them, I will say, of a rather sensational character, insisting that there is discrimination in medical schools against those of the Jewish faith, against Italians, against Negroes, and so on; and you are familiar with these articles?

Dr. WEISKOTTEN. Yes, sir.

Mr. BIEMILLER. May I inquire, has the council at any time made a study of that situation, and has there been any answer made, so to speak, to any of those articles?

Dr. WEISKOTTEN. No. Certain schools have made studies of their own schools, and been called upon to demonstrate that they were not discriminating. And I think that they have all been able to do it where they were called upon to do that.

Mr. BIEMILLER. If there was such information available, I think the committee would like to have it, if we could get our hands on it, because we are going to run into those charges from time to time as the hearing continues.

Dr. WEISKOTTEN. It may be that the representatives of the Association of American Medical Colleges may have some data in that regard.

Mr. BIEMILLER. We will inquire from those gentlemen. I realize that that is not as much in your province as it would be in theirs.

Thank you.

Mr. Wilson. Mr. Chairman, I would like to ask the doctor a question or two, but before I do, I think that I would like to say this for the record and to the committee and in fairness to the gentleman, that it should be so stated by the Chair that in presenting any proposed amendments, that it would not, even by inference, be considered that they would endorse the program if they do not want to.

Mr. Priest. Certainly, and I am glad that you emphasized that.

Dr. Weiskotten. That is why I hesitated for a moment.

Mr. Wilson. I think in fairness to these gentlemen, that should be so stated by the chairman of this committee.

Mr. Priest. The chairman does so state. And the chairman, of course, had no other thought in mind than that these suggested amendments would be helpful, but would not in any way indicate that you approved the legislation if the amendments were adopted. It would not be necessary to indicate that.

Dr. Weiskotten. I appreciate that, yes, sir.

Mr. Wilson. I want to call the doctor's attention to the fact that in the Surgeon General's statement, he also talked about academic freedom. Now, quoting his statement:

> Coming now to the problem of the best method of providing aid to the schools, we believe that it is sound to rely on an objective formula—as provided in both bills—which is as self-executing as possible, which leaves the minimum amount of discretion in the Federal administering agency, and which gives the maximum protection to academic freedom.

I call that to your attention to show that the Federal authorities just preceding you have also emphasized academic freedom.

Dr. Weiskotten. I knew that he did feel that way about it.

Mr. Wilson. I would like to follow along the lines asked by Congressman Sadowski about your objection to regimenting the youth who has gone through medical school. I do not know, personally, that I subscribe to everything that has been said, as to whether it is regimentation. For years and years we had a system at our service acadamies, and maybe we have been regimenting the young men who go through West Point and Annapolis; however, we provide them with thousands and thousands of dollars of educational funds, the best education available, and we expect them to be part of the establishment to defend our Nation in time of need; and we demand of him, on the other hand, that he shall devote at least a part of his time after graduation to the service to his country.

Maybe that has been regimentation. I do not know whether it would be an adequate excuse for saying that this would be regimentation of young doctors simply to say that there would be required a part of the best years, the first 2 years after he gets out of medical school—is that the basis of your objection as to regimentation?

Dr. Weiskotten. Dr. Anderson says he would like to reply to that.

Dr. Anderson. We like very much better the provision in H. R. 3894 than the provision in these bills. You will recall that in H. R. 3894, the requirement was that a man who has gone through medical school on a Government scholarship should practice his profession for 5 years. There was no other stipulation.

It is our feeling that this man that you help to go through school is going to pay back to the country, over a lifetime devoted to the practice of medicine, in service and aid to the people for the assistance that you have given him. He is going to make his repayment in that way, rather than in a specific period of 1, 2, or 3 years, or whatever it may be. Your purpose in aiding these men is to have better doctors for the American people.

Mr. **Wilson**. I think it is commendable to have better doctors for the American people, but at the same time there has been an expenditure of "X" dollars provided by the American people for that education. It is providing something to humanity to put him in the channel of making him a good doctor. At the same time, the doctor is human, and he lives for the purpose of creating a livelihood for himself and his family that he wants and he is expected to have; and at the same time there is at least a little tug there on the moral side that they should restore to their Government some service. Do you not think, Doctor, really, that that factor is present?

Dr. **Anderson**. Possibly this is the answer. It is estimated that the average physician donates between one-sixth and one-third of his time without charge throughout his lifetime. This service probably would amount, in terms of dollar value to the American people, to more than the amount they will pay in educating him. It is estimated, for instance, that physicians each day give about $1,000,000 of free medical care, in their offices or hospitals or other agencies. So I think that physicians aided by scholarships will, as a group, be repaying adequately for the assistance they receive, whether each individual repays specifically.

Mr. **Wilson**. I can appreciate what the doctor has said, that here you ask a man who has a potential capacity to be a research man to go off in any community and take over an area where people themselves have failed to provide inducements to draw him there. I can see that that would be a disservice to humanity in asking one who has the capabilities, and who has been developed through these scholarships and study in medical schools, to do that. But what percentage of the graduates from medical schools pursue the specialized lines?

Dr. **Weiskotten**. Too many of them.

Mr. **Wilson**. What is that percentage?

Dr. **Weiskotten**. In regard to aid, I might say this, Mr. Wilson: Based on my own experience over a period of 27 years, not a single student has ever discontinued the study of medicine at Syracuse University College of Medicine, or even stayed out a year, for financial reasons. I have loaned thousands of dollars to needy students, and I have never lost one cent of interest or principal in those 27 years. My interest is loan funds that are repaid.

Mr. **Wilson**. Has not that very thing shown a desire on the part of men in that profession to meet their moral obligations to pay that money back?

Dr. **Weiskotten**. Surely.

Mr. **Wilson**. And it shows the character of the profession.

Dr. **Weiskotten**. Yes, sir.

Mr. **Wilson**. What percentage of the graduates are entering the specialized lines; could you give that approximately or roughly?

Dr. **Weiskotten**. It is very difficult to do that. I started a study of that sort at 5-year intervals back in 1915. I study the students when they are 5 or 6 years out of college to find out what they are doing. I have studied the graduates of 1915, and 1920, and 1925, and 1930. But

6 years after 1935 we were at war, and there was so much displacement that it was not possible to make an accurate study, and the same thing is true with the graduates of 1940 and 1945.

The percentage on my last study was something over 30 percent entering a specialty. I am sure the percentage is much higher than that today.

Mr. PRIEST. Dr. Weiskotten and Dr. Anderson, we thank you both for your appearance before the committee and for your testimony.

Dr. WEISKOTTEN. Thank you very much, Mr. Chairman and members of the committee.

Mr. PRIEST. Is Dr. Hinsey in the room?

We are running behind our schedule, but we hope if possible to hear Dr. Hinsey and Dr. Ezell before we adjourn. We will proceed expeditiously.

STATEMENT OF DR. JOSEPH HINSEY, CHAIRMAN OF THE EXECUTIVE COUNCIL, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AND DEAN OF THE CORNELL UNIVERSITY MEDICAL COLLEGE, NEW YORK CITY, N. Y.

Dr. HINSEY. Mr. Chairman, I will make a very short statement to you at this time, and then will be glad to answer any questions.

At present there are 71 approved 4-year medical colleges and 7 approved schools of basic sciences in the United States. Forty-three of these schools are privately supported and 35 are tax-supported. Sixty-eight schools are integral departments of universities. Ten are independent institutions without university affiliations. In the year 1947–48, there were 22,248 students in attendance in all 4 classes and 5,543 physicians were graduated. During the current academic year, approximately 5,150 students will graduate. This present fourth-year class is small because it was selected in the last year of the war when there was no provision for the deferment of premedical students by the Selective Service System. This decrease in number of graduates is temporary, and the total number of graduates will increase next year. The enrollment of 22,739 students during 1947–48 is 1,212 greater than the average during the 5-year period preceding the war, despite the fact that the then third-year class was small.

During the present academic year, these 78 schools are operating on budgets which total about $51,000,000, of which $12,800,000 is derived from student fees; $20,700,000 from endowment income, gifts, and general university funds for deficit financing; and $17,500,000 from tax sources. The average tuition is $513, the maximum being $830 and the minimum under $100 in one of the State institutions. Although it is a difficult matter to state definitely, it is estimated that the average cost per student is about $2,200 with a range from $735 to over $5,000. Sixteen schools spend less than $1,500 per student and 39 more than $2,000.

Today, medical education is the most expensive of all forms of education. Many factors combine to make this so. The primary factor is that every prospective physician must undergo an intensive period of individual study in classrooms, laboratories, and hospitals before he can be allowed to assume responsibility for the life and health of his fellowmen. The training of doctors involves a large number of highly skilled teachers in proportion to the number of students—teachers who must be paid salaries which are not too far out of line with those they could command in private practice or in business or industry. It requires extensive laboratory facilities and specialized equipment which are costly to secure and to maintain. It involves the use of vast clinical facilities in hospitals and clinics where patients of every type may be cared for and studied. These are some of the reasons that the medical schools today present a great financial problem. The costs per instruction would be greater if it were not for the donations of time by many physicians who devote only a part of their time to teaching and if it were not for the costs that are carried by many of our great teaching hospitals.

The Association of American Medical Colleges is an educational association made up of the approved medical colleges of the United States and Canada, including the College of Medicine of the University of the Philippines. It will hold its sixtieth annual meeting this coming fall. Its central office is at 5 South Wabash Avenue, Chicago, Ill., and its full-time secretary is Dr. Dean F. Smiley. It is devoted to problems of medical education, and publishes the only journal devoted solely to this field.

Senate bill 1453, which is the companion bill with House of Representatives bill 3894, was sent to the deans of all 78 approved medical colleges in the United States on April 12, 1949. They were requested to study this bill and discuss it with their appropriate university authorities and to send in their reactions to it. The provisions for aid to medical education in H. R. 3894 are quite similar to those in H. R. 4312. The testimony to be offered reflects the opinions received on H. R. 3894 from 55 of the schools which were about equally divided between privately supported and tax-supported institutions. Although I have no definite information from our schools, it would be my impression that they would in the large majority favor that medical education be provided aid under a separate bill like H. R. 3894 than in an omnibus bill like H. R. 4312. Some deans think that it would be preferable to provide for medical, dental, and graduate public health education in one bill and for nursing and dental hygiene in another.

With respect to additional students, these 55 schools estimate that 608 students could be added to their entering classes with the aid of new construction provided in the bill. Twenty-eight of these 55 schools estimate that their share of new construction would be $60,400,000. Of these 28 schools, 12 privately supported ones estimate their share to be $16,525,000, and there was doubt expressed over ability to raise construction money in some instances. About $43,875,000 represents the estimates from 16 tax-supported institutions. The suggestion was made that it would be better to provide for construction on a basis of matching of two parts from Federal funds to one from the institution.

The comments from 30 institutions criticized the $300 per student maintenance fee. This amount would help, but in school after school it would provide only a fraction of the present need. In addition to undergraduate medical students, all medical schools carry a very considerable number of what may be termed graduate students which include interns, assistant residents, residents, and fellows. These are the responsibility of medical schools in teaching hospitals and occupy a great deal of the time of the clinical departments. Some of these are found in the basic science departments. It was suggested that the medical schools should press for the recognition of these individuals as members of their student bodies since they are students completing their medical education.

The difference between the $300 per student now enrolled and the $1,700 incentive for new students was criticized by 35 schools as being too great. Fear was expressed that incentive of $1,700 would cause schools to expand beyond their facilities and thus lower their standards of medical education. A number commented that $1,700 was not enough to carry the cost. There was general concern as to how long this sum of $1,700 for new students would be provided. If a school should build up its budget with this in mind and make appointments with tenure, it would be disastrous to have it stopped abruptly. The same concern applies to the $300 per student now enrolled. Without assurance of continued support, it would be equivalent to building up greater deficits and experienced administrators will not do this. If we were to include the student body at the University of Washington, which will have a 4-year program in operation next year, and that at the Chicago Medical School, which was approved last fall, the total student enrollment for next year would approximate 23,000, of which about 7,000 will be in the first year class. At the rate of $300 per student, this would require $6,900,000. From the 55 schools included in this report, the rate of addition of new students was about 11 per school per year. If this rate were maintained for all 78 schools, the cost at $1,700 per each additional student would be about $1,460,000 per year; and over 4 years, this would approximate $5,800,000 per year. However, it should be remembered that the increase in some institutions was contingent upon funds for construction and new buildings, which would take time. The University of California at Los Angeles has started the organization of a new medical school, but students have not been accepted there as yet.

In regard to the scholarship program of H. R. 3894, there was prevalent concern about the necessity of establishing need on the part of the candidates. There was quite general apprehension about political pressures upon admissions committees and officers if the scholarships are to be awarded before admission to medical schools. Many schools believe that the scholarship awards should be made to those already admitted to medical schools. Many schools are opposed to the requirement of indentured service upon completion of training. However, H. S. 4312 does provide a release clause.

Several schools recommended that a loan program would be better with a provision made for allowance for retirement of a loan at an annual rate for (*a*) service in governmental agencies, (*b*) teaching and research, or (*c*) for service in rural areas with low physician populations. With the GI bill benefits gradually passing out of the picture, there will be need for student aid of some type, but schools must be free to select students on a fair basis. There are provisions in H. R. 3894 and H. R. 4312 to protect this freedom. Ten schools doubted the need and the wisdom of such a program at present.

Of the 55 schools from whom comments have been received, 16 favor the National Council on Education for Health Professions.

Among the remaining 39, there were expressions that this would indirectly place too much power in the hands of the Surgeon General of the Public Health Service.

Among the recommendations that were made are the following:

That the functions of this council should be more clearly delineated; that it should have power to recommend and approve projects and programs; that consideration might be given to ex officio representatives from some of the national organizations in the various fields of health education.

Attention should be paid to determine how many additional physicians are needed. In addition to the new 4-year medical schools already mentioned, that is, the University of Washington at Seattle, the Chicago Medical School, and the University of California at Los Angeles, a new 4-year school is being organized in North Carolina and the State of New York is deciding where to locate two State medical schools. North Dakota, Mississippi, West Virginia, Florida, Missouri, New Jersey, and Connecticut are considering the possibility of 4-year schools. If legislation like H. R. 3894 or H. R. 4312 is passed, half the costs of construction would be shared by the Federal Government, and each student might mean an outlay of $850 per year. State legislatures have exerted pressures to increase numbers of admissions to their medical students. Is there to be a ceiling, or are we to pursue unlimited expansion? Problems created by shortages in teaching personnel already existing in some fields can be greatly exaggerated in an uncontrolled expansion.

H. R. 3894 and H. R. 4312 place most of the emphasis upon expansion of numbers of students in medicine and too little upon the maintenance of standards and quality in our present operations. The latter constitutes the most urgent need in the health training picture. Exact data supporting this need are not available now, but are being obtained. The plight of our voluntary teaching hospitals is one that is affecting the whole program of medical education. The inflationary cycle has caused increases to costs to the point where many of them are running large deficits which are being met out of capital funds. This cannot go on, and is already exerting a deteriorating effect on undergraduate and graduate medical education. A survey on medical education is now under way, supported from private sources. This will provide much useful information for long-term planning. The study now being conducted by the National Advisory Health Council is designed to study the impact of the grant program of the United States Public Health Service on medical education, but it is bringing together data which pertain to the present financial structure of medical schools.

The Association of American Medical Colleges fully appreciates the plight of many of its member colleges and the effort they are making to maintain and improve the quality of their work. We do not oppose expansion of numbers and have not in the past, but we feel it is our obligation to emphasize that the goal should be determined and that the final product should be well trained in the best interests of the improvement of our national health.

It has been difficult to summarize all of the reactions received. The following statements may sum up our general position:

I. There is a definite need now for Federal aid to medical education provided the educational and administrative policies can continue to rest in the hands of the medical colleges without political interference and with the maintenance of academic freedom.

II. Such aid should not interfere with private and State aid.

III. Aid to students should have a need qualification. If there is any indentured service, it must have an escape clause. Scholarships should be awarded to those already admitted to medical schools. Many educators prefer aid in the form of loans, others prefer gifts instead of loans in view of the long training period.

IV. Attention must be given to the maintenance of standards in the present medical school operations. Incentives for new students must not be so attractive as to cause expansion beyond facilities and at too rapid a rate.

Dr. Alan Gregg, the director of medical sciences of the Rockefeller Foundation, has been associated with this foundation for the past 27 years, and has closely followed and been identified with the development of medical education. Recently he said:

> I wonder if Americans understand how alarming is the future of medical education in this country. Unless our medical schools receive substantially larger sums for their essential expenses, we shall not in the future have the care which modern medicine could provide. For it is only through the hands of men and women trained by our medical schools that society provides itself with medical care.

Mr. Chairman, we have had a group of people, including Dr. Ward Darley, who is the director of medical sciences and health services at the University of Colorado, and Dr. Carlyle Jacobson of the University of Iowa, the executive dean of health sciences; Dr. Walter Bloedorn, dean at George Washington, and Dr. George Berry, who is now associate dean at Rochester University and dean-elect at Harvard. This statement has been approved by the council of this association, after I prepared it.

I would be glad to answer questions. This statement presents our position in terms of a survey that has been made among the deans of our medical colleges over the country.

You may wonder why there is a discrepancy of 71 approved (4-year schools) medical colleges, and the 72 that was stated by Dr. Anderson. It happens that one of the 4-year schools has not been finally approved, but it will be within a year. That is the University of Washington at Seattle.

Mr. PRIEST. There were some questions that had been directed to other witnesses by the members of the committee on some particular matters, and in these instances it has been suggested that you might have the answers to these questions. I do not recall those questions, but perhaps Mr. Sadowski does. He had a question, and it was suggested that Dr. Hinsey might have the answer to that question.

Mr. BIEMILLER. I had a question on the continuous allegations of discrimination—the articles that have been written in magazines.

Dr. HINSEY. We realize that those have been made, and some of them have been answered. For example, there was an article in the Saturday Evening Post by Henry Pringle on the Color Line in Medicine, in which some of our institutions were severely criticized. My own institution happened to be one, and the only opportunity we had to answer was through the letters to the editor. We were able to establish beyond any question that we had Negro undergraduate medical students in our student body who were admitted in competition with other students on the basis of their preparation and their overall qualifications. We were also able to show that we had within our hospital Negro physicians who had come to us from other institutions for graduate training.

Mr. **Biemiller.** What school is that?

Dr. **Hinsey.** Cornell.

Mr. **Biemiller.** That is my own school. Good. I am not surprised.

Dr. **Hinsey.** In regard to the other problem of discrimination, I can tell you honestly that I do not know the race or the religion of any of our students. I do not pay any attention to that. We are interested in them as individuals, and I could not tell you how many of any racial group we have in our institution. We do have representation of the so-called minority groups, and I can tell you beyond any question. I could not tell you how many of any one, because I am not interested in that.

I think that I can say, too, that some of the investigations that have been made have failed to prove the allegations. There have been some interpretations that have been made that have not been really substantiated.

I do not believe any of our schools have made a study of this point, because we do not believe, first of all, that we could get accurate statistics.

Mr. **Biemiller.** Does your application blank, for example, provide for a statement as to race or nationality or religion or anything of that sort?

Dr. **Hinsey.** No, sir, it does not.

Mr. **Biemiller.** Do you require pictures?

Dr. **Hinsey.** We do, as they do in the university. But as you may know, in New York we are operating under a State antidiscrimination law, and I think that there are ample means there that if there are any unfair practices, they will be unearthed.

Mr. **Biemiller.** I think that that is very true. Of course, I am also proud of the fact that over the years Cornell has had a very fine record on the question of discrimination, and I like to remind members on the floor of the House of that fact every now and then.

There is one other question that was at least indirectly coming back to your position. I raised the question about the difficulty of people transferring from the 2-year school to the 4-year school. Do you agree that is going to be an ever-increasing problem through the years?

Dr. **Hinsey.** As a matter of fact, I don't believe it will be as great a problem in the years to come as it may have been in the past. For a good many years we have taken transfers from the University of Alabama, from the University of North Carolina, Dartmouth, from the University of West Virginia, from the University of Mississippi, and other 2-year schools, and in years past from the University of Wisconsin, at the time when they were not able to carry their students all of the way through the 4 years. A number of those schools, like Alabama, are now 4-year schools, and North Carolina is planning to be a 4-year school. There are openings that occur in the third year, and we are very interested in being able to fill those openings with people from the schools of basic medical science.

We have had a very fine group of students that have been coming through to us in these last few years. We would like to have as few vacancies as possible, and we want to reduce that matter of attrition to the lowest possible level, because if we can save 5 or 10 percent, that is the equivalent of several medical schools. Some schools are having difficulty this year, but I know that there is a sincere interest on the part of 4-year schools over the country in trying to provide for those students.

In certain of the 4-year schools the amplification and enlarging of clinical facilities may make it possible for some to enlarge the student bodies in the third and fourth year. For example, Washington University in St. Louis has for many years taken quite a few students from the University of Missouri. If the University of Missouri establishes a 4-year school, as has been indicated to me, this will reduce the supply of 2-year students to that institution. I cannot predict what will be the trend in regard to these schools of basic medical science, but I can say that a number of them have done an excellent job of training.

Mr. **Biemiller.** I recently received a rather complicated protest, and I think that I recall it accurately, from a young man who had seen that I was a sponsor of this current legislation. It ran something like this: He was in a good medical school and he was right in the top rank, at least he told me that. About 1940 this particular school had to again weed some people out, at the end of the 2 years. This is a 4-year school, but they did some weeding out, I gather because of the space problem, or at least that is the story. This young man in turn went on and took a dentistry degree there, and he is now a practicing dentist; but he is anxious to get into a medical school, and he cannot find any opening. Is that any kind of a normal situation?

Dr. **Hinsey.** I do not think so. Of course, I would have to know more about this case. There has been some difficulty in the placing of some of the men from 2-year schools this year, but I believe that the trend toward the 4-year school that has taken place already and will take place, among institutions which I have indicated in my summary statement, will reduce that demand. As a matter of fact some of us hope that there will continue to be schools of basic medical science.

There was another question that was brought up, if you would like to have a comment. There was a question in regard to the number of students that are graduated now as contrasted to those 25 years ago; and I think if we look in 1929 there were 4,446, and in 1948 there were 5,543. That is about 1,100 increase.

The incoming class this next fall looks as though it will be about 7,000, in that neighborhood. Last year the number was in the neighborhood of 6,300, and that is an increase of 700.

Mr. **Sadowski.** If you could take care of all of the applicants applying now, how many would that be?

Dr. **Hinsey.** I would like to comment on that. That question has been raised.

With the multiple application procedure, one student will apply to several different schools, and you hear about the number of applications in any one school and the number of places. Take our own institution. This year we accepted 84 students, and we had in the neighborhood of 3,300 applications. That looks like a terrific discrepancy, but with multiple applications, the essential point is: How many real people are there that are applying? And a more essential one is: how many qualified people are applying?

Before the war, the ratio of the number of people applying to the number of people who were accepted was something like 2 to 1. This last year, because of the piling up of the GI's in the postwar period, there were 19,000 to 20,000 actual people (I hesitate to give the actual number because I do not remember exactly, but it was in that neighborhood); applying for some 6,000 or 6,300 places.

Mr. SADOWSKI. What is that again?

Dr. HINSEY. There were about 20,000 people applying for about 6,300 places. But the essential thing there is: How many of those 20,000 people were really qualified, as we accept in our institution applications from anyone who wants to give them to us.

On the basis of scholastic requirements, health requirements, possibly ones of over-all personality, some of those people are just not qualified.

Mr. BIEMILLER. Would you mind expanding—and I realize you cannot give us infinite detail on it—on what you mean by this personality question? That keeps coming up all of the time.

Dr. HINSEY. Well, we mean people who are fundamentally honest, and emotionally stable, who have an interest in their fellowmen, the milk of human kindness, who are curious, who are willing to work, who are industrious, are resourceful, and imaginative. It is the sort of thing that is extremely difficult to put into words, but it is something that with experience people learn to assay. We rely upon information from people who have known them in their home communities, from their teachers in the universities, possibly from physicians who have known them, and our source of information is a large one. Then we have interviews, and we do our dead level best to try to survey the over all. I cannot tell you in words what I mean, but I think I know something about evaluating it.

Mr. BIEMILLER. Could you give us a rough estimate of the percentage of applicants that you actually interview?

Dr. HINSEY. Well, that varies in different institutions, Mr. Biemiller, and I would hesitate to say. In some institutions they try to interview all. Take, for example, a State institution could do that. Some institutions receive applications from all over the country—for example, in our institution we have students from some 40 different States, and it is difficult for us to interview those out in the Northwest or the Southwest or the deep South. But we rely on the evaluation of the people in their universities and colleges; and then at times we ask them to go to see people that we know,and who know our institution. It cannot all be immediate interviews. I do not have the figures on the actual number of interviews in our own institution, but we send a committee to Ithaca to meet with all of the students applying there at Cornell.

Mr. BIEMILLER. I remember some of those committees.

Now, you stated that you had roughly 3,300 applications.

Dr. HINSEY. Yes, sir.

Mr. BIEMILLER. For 80 positions.

Dr. HINSEY. Yes, sir; 84 to be exact.

Mr. BIEMILLER. As I recall, the figures at Wisconsin were 2,900 for 80 spots?

Dr. HINSEY. Yes, sir.

Mr. BIEMILLER. And I would assume that it goes without saying there would be a great deal of duplication in the 2,900 and 3,300?

Dr. HINSEY. That is right.

Mr. BIEMILLER. That would be true of Yale and all of the other schools.

Dr. HINSEY. That is right.

Mr. SADOWSKI. I would like to ask a question.

You stated that in 1948 you graduated 5,543 physicians, and that it is going to drop to 5,150 for this year?

Dr. HINSEY. That is right.

Mr. SADOWSKI. And you gave your reasons for that?

Dr. HINSEY. Yes, sir.

Mr. SADOWSKI. That was the result of the Selective Service System. Do you anticipate an increase next year?

Dr. HINSEY. Yes, sir.

Mr. SADOWSKI. I suppose that would be over the figure of 5,543.

Dr. HINSEY. I imagine it will be, because we will have some graduates from schools that are not in that compilation, Mr. Sadowski.

For example, the Chicago Medical School in Chicago was approved during the last year, and it will have a group of graduates that are not in that figure, and there will be some graduates from the University of Washington, and I could not tell you what the over-all number would be. I think that I could give you some rough estimate of it, though, and it would be a rough one. We know the number in the preesnt third-year class to be something over 5,500. That does not include the graduates of the Chicago Medical School or the University of Washington at Seattle, so that there will be an increase this coming year.

Mr. SADOWSKI. You say about 7,000 will enroll this year?

Dr. HINSEY. That is an estimate.

Mr. SADOWSKI. At graduation time, how many of those 7,000 will actually graduate?

Dr. HINSEY. I could not tell you, but I would say that the attrition varies, but it would probably be somewhere between 10 to 15 percent. That varies from year to year. We hope that there won't be any attrition, but students do drop out in spite of the best methods we use in selection. And there are sometimes students that change their minds as to whether they want to go on into medicine. Their finances run low and there are problems of health.

Mr. SADOWSKI. We might hope to have about 6,000, approximately.

Dr. HINSEY. That is right; possibly more up to 6,500.

Mr. SADOWSKI. That would be the saturation point, and it would leave the other people out of the schools and colleges. That is all they could handle at the present time, unless they are provided with additional facilities?

Dr. HINSEY. I believe our schools have done everything in their power to really handle that.

Mr. SADOWSKI. I mean 6,000 students a year would be the saturation point.

Dr. HINSEY. Under our present facilities, that is right for the number of graduates.

Previously I have indicated the evaluations that the schools have given if they had finances to increase their facilities, that they estimate somewhere in the neighborhood of about 11 per school; that is an average, and it is a little bit difficult to take that over-all. That is on the basis of 55 schools.

Mr. WILSON. Mr. Chairman, I notice from the witness' statement he has made a recommendation which reads something like this: "Aid to students should have a need qualification. If there is any indentured service, it must have an escape clause."

Dr. HINSEY. There is one in the bill. I covered that in the major portion of my statement, Mr. Wilson.

Mr. WILSON. I wanted your further comment on that.

Dr. HINSEY. That is in there, and in the major portion of my statement you will see that in addition to the Federal services and services in rural areas, there is a strong feeling and recommendation on the part of many of our deans that credit should be given for teaching and research in our various institutions. That is, if a man would go into teaching or research, whether it be governmental or one of the medical schools or hospitals, that that would be accredited as the time in Federal service or in a rural area.

Mr. WILSON. I notice on page 8 of your statement you make this remark:

> We do not oppose expansion of numbers—

meaning the numbers of students in the medical schools—

> and have not in the past, but we feel it our obligation to emphasize that the goal should be determined and that the final product should be well-trained in the best interests of the improvement of our national health.

Such support as you give to title I of this bill embraces that thought, that there must be an increase of members but when the increases come they must be good products?

Dr. HINSEY. We feel that one of the greatest needs today is in the strengthening of the present operation, and I wanted to emphasize that; sometimes we have been accused of trying to hold the numbers down. That is not true. We have helped schools that have been trying to formulate a program that would be approved. But if there is to be an increase, we want that increase to be of a standard that is of a high quality. That is our aim.

Mr. PRIEST. Doctor, without seeking to commit you to any specific language, is it the general feeling in the American Association of Colleges that the broad objective of title I of the bill we are considering, and of Mr. Biemiller's bill, H. R. 3894, are worthy of your support?

Dr. HINSEY. I would say certain changes, that I think are covered in my statement should be made. I could not commit our association because there is a variety of opinion there, but as I judge the over-all, if certain safeguards that are outlined in here are made, I believe the majority would think so.

Mr. PRIEST. Thank you so much, Doctor. It has been a real pleasure to hear you.

Mr. WILSON. May I state to the witness that the preceding witness handed me his analysis, and I presume that you wanted that in the record.

Mr. PRIEST. That has already been placed in the record.

Thank you so much, Doctor.

Dr. HINSEY. I appreciate having the opportunity, and I am sorry to have kept you so late.

Mr. PRIEST. Dr. Ezell, will you come forward?

STATEMENT OF DR. WILLIAM C. EZELL, PRESIDENT, AMERICAN OPTOMETRIC FOUNDATION, SPARTANBURG, S. C.

Dr. Ezell. Mr. Chairman, I will submit a copy of my statement, and in order to further conserve time I have written down a few remarks. I do want to call to your attention some of the principal things that I outlined in this statement.

Mr. Priest. That will be done.

(The statement is as follows:)

It is set up in the same manner as are similar organizations representing other professions. The individual optometrist joints his local association. In a few of the smaller States, there are no local organizations and the optometrist joins the State association directly. In the larger States there are local, district, or zone groups. Upon joining the local organization, the optometrist automatically becomes a member of his State and national associations and so also when he becomes a member of his State association, he likewise becomes a member of the national association.

A recent survey indicates that there are about 17,500 optometrists licensed and registered in the 48 States and the District of Columbia, of whom approximately 14,500 are actively engaged in practice. These figures are conservative because during the past several years there has been a substantial number of veterans who have returned to interrupted optometry courses and have graduated and been licensed.

There are nine accredited schools and colleges of optometry. These are accredited by the Council on Education and Professional Guidance of the American Optometric Association and graduation from one of these accredited schools is a prerequisite for admission to a licensing examination. Just as in medicine, dentistry, and the other health professions, the statutes in the individual States provide for boards of examiners in optometry and these boards have assigned to them the functions of licensing and regulating the practitioners of optometry.

Most of the accredited schools are presently giving 5-year professional courses and commencing September 1, 1949, this fall, all schools will give a 5-year course in optometry.

Optometrists are the only persons engaged in the health field who are specifically trained and especially examined and licensed to care for human vision. Their entire educational process is devoted exclusively to the care and betterment of vision and optometrists may factually state that they are the only exclusively licensed vision specialists in the health care field.

Seven out of ten person who require visual care voluntarily seek the services of optometrists and become their patients. The other three are the patients of either the opthalmologist or the occulist. Eminent ophthalmologists have admitted in their writings that the percentage ranges between 75 and 80 percent but we are content to take the lower figure.

We respectfully contend that the care of vision is not an incidental phase of health care and should not be grouped with auxiliary services. I do not think that this point need be emphasized by dry statistics. The members of the committee need but think for a moment of how many people they meet daily who use eyeglasses. This is an indication that the wearer has found it necessary to obtain visual care. Suffice it to say that 70 percent of all persons over 40 years of age have visual problems necessitating the use of glasses. In addition, spot surveys made in different industries indicate that there are many people who have visual problems and who should have these problems corrected, who today through ignorance or neglect are going around with impaired vision.

The very vastness of the visual problem in the United States is such that it is not a secondary or auxiliary health requirement. It not only has health but social aspects which are equally important. Without comfortable and efficient vision, the worker cannot properly turn out his work; the inefficiency of vision lowers his productivity, decreases his own earning power, and impairs the quality and quantity of his employer's product. It was clearly demonstrated during the war that the problems of industrial vision must be met. Good clear vision not only increases the usefulness of the worker, but also tends to protect him from injury and adds to his happiness as well.

Because optometry filled a need in the health care field which medicine either failed to see or neglected, it has become over the last 50 years, an established and important profession. Optometry is an independent profession, independent in the sense that the person who seeks visual care may of his own free will, seek the services of the optometrist without being referred to him by anybody. The patient not only selects the individual practitioner of his choice but also the type of practitioner. Because of the excellence of the service and its need and usefulness, optometry has attracted and holds at least 70 percent of the patients. They are now and should be free to select an optometrist of their own choosing.

The same shortage which exists in the other health care fields mentioned in the bills before your committee likewise exists in optometry.

It is almost inconceivable to think that bills with avowed broad social purposes should completely omit and totally disregard the profession of optometry. This is not stated from a selfish or self-centered point of view. Our point is that it is the public who are being neglected if no provision is made to make grants to optometry schools and supply scholarships to prospective optometry students.

Once one arrives at the age of 40, he soon needs visual care and his vision must be corrected by eyeglasses. This is the result not of any human activity or neglect but it is the inevitable result of one of the acts of nature. The human eye, after 40 years of age, no longer can accommodate itself to the visual requirements of life.

Therefore 70 percent of the persons over 40 years of age immediately require visual care, the need increasing until in persons of 70 years, 96 percent of them require visual care and visual aids in the form of eyeglasses. Many of these persons as well as the younger people requiring visual care are not served today because, by reason of the war and other circumstances, there is a need for more optometrists, just as there is a need for more practitioners in the other health fields. Nevertheless, as stated before, 7 out of 10 of this huge number of persons requiring visual care are served by members of the optometric profession. They are served satisfactorily and their visual needs receive proper care. Again this is not intended to be a boastful statement but a factual one.

Since the declared purpose of these bills is to improve the health and welfare of the people of the United States, such purpose cannot be completely accomplished if the profession of optometry is overlooked or deliberately omitted. The public which is presently receiving optometric care and is seemingly satisfied with it should not be deprived of a continuance and a proper expansion of this care. Optometry is not a part of any other profession. It is a separate, distinct, and independent profession. It has grown up as such during the last 50 years.

The bills before the committee should not be utilized to blot out an established profession; one which has served honorably and satisfactorily for 50 years. These bills in the desire to grant the public greater health care should recognize the existence of the profession of optometry and the professional service which its practitioners give to 70 percent of those who seek visual care.

Most of the advances of the science of seeing and in the correction of vision have taken place in this country, and they have been the result of the work of optometrists, physicists, and other optical specialists who are not medical practitioners. To completely eliminate a profession so vitally concerned with and a part of the present health care of the people of the United States from the same grants to optometric schools and scholarships to optometric students as are provided for schools and students in other health professions would have the tendency of stifling the profession, to the consequent detriment of the public.

No bill, including the ones under discussion, should have the effect of reversing the progress of the profession of optometry in caring for the visual needs of the American public or of accomplishing, by indirection, the aborting or stifling of the profession, thereby shearing it of its independence and relegating it and its practitioners to the satus of technicians.

In advancing the health and welfare of the people of this country as these bills propose to do, the Congress should not curtail the fine optometric care which millions of patients are now receiving.

We respectfully ask leave to submit specific amendments to title I and to H. R. 3894.

Dr. EZELL. My name is William C. Ezell, and I reside in Spartanburg, S. C. I am president of the American Optometric Foundation. I am also a past president of the American Optometric Association.

The foundation is an eleemosynary corporation for research, scholarships, and professional advancement.

May I give you, Mr. Chairman, a copy of the foundation brochure so that you can get a better idea as to what the foundation is. Other copies are available if any of the other members would like to have them.

There are over 17,500 practicing optometrists licensed to practice in the 48 States and the District of Columbia. Of course, the big majority are in actual practice. There are nine accredited schools, all accredited by the Council on Education and Professional Guidance of the American Optometric Association. All students must pass the State board examinations before practicing.

By September 1, 1949, all of the accredited schools will give a 5-year course in optometry, all devoted exclusively to the care and betterment of vision.

Seven out of 10 persons voluntarily go to the optometrist for visual care.

Optometry is not an auxiliary service and should not be so classed in this bill. It is not an incidental phase of health care. Seventy percent of people over 40 years of age require visual care, and go directly to the optometrist, oculist, or ophthalmologist, and go to the man of their choice. They should be allowed to continue this custom without the necessity of being referred by another agency, as under this bill.

The same shortage exists in optometry as in the other health-care fields. It is inconceivable that this bill would totally disregard the profession of optometry.

The public will be neglected if no provision is made for grants to optometry schools and to the supplying of scholarships to prospective optometry students.

The bills before this committee should not be used to blot out such an important public service profession as optometry. Most advances in visual care have taken place in this country, and are the result of the work of optometrists, physicists, and other optical specialists who are not medical practitioners.

In advancing the health and welfare of the people of this country as these bills propose to do, the Congress should not curtail the fine optometric care which millions of patients are now receiving.

We respectfully ask leave to submit specific amendments to title I and to H. R. 3894.

Mr. Priest. We will be very happy, Doctor, to receive any suggested amendments that you care to submit to the committee.

(The proposed amendments referred to are as follows:)

Amendments Proposed by the American Optometric Association to H. R. 4312 and H. R. 4313

1. On page 6, line 9, between the words "hygienists" and "nurses", insert the word "optometrists,".

2. On page 10, line 21, between the words "hygienists" and "nurses", insert the word "optometrists,".

3. On page 11, line 19, after the word "hygiene", insert the word "optometric,".

4. On page 12, line 10, between the words "hygiene" and "nursing", insert the word "optometry,".

5. Page 14, after line 17, insert the following new paragraph:

"(6) to each school of optometry which provides training leading to a degree in optometry or an equivalent degree, $250 for each student enrolled for such training up to its average past enrollment, and $1,300 for each student so enrolled in excess of its average past enrollment."

6. On page 16, line 6, between the words "hygiene" and "nursing", insert the word "optometric,".

7. On page 17, line 19, between the words "hygiene" and "sanitary", insert the word "optometric,".
8. On page 22, line 16, between the words "hygiene" and "nursing", insert the word "optometry,".
9. On page 24, line 3, after the word "degree", strike out the period and insert in lieu thereof a semicolon.
10. On page 24, after line 3, insert the following new paragraph:

"(7) scholarships to schools of optometry providing training leading to a degree in optometry or an equivalent degree."

11. On page 25, line 18, between the words "hygiene" and "nursing", insert the word "optometry,".
12. On page 30, line 20, between the words "hygiene" and "schools", insert the words "schools of optometry,".
13. On page 32, line 5, between the words "dental" and "nursing", insert the word "optometric,".
14. On page 32, line 20, after the word "hygiene", insert the word "optometric,".

Amendments Proposed by the American Optometric Association to H. R. 3894

1. In line 3 of the title, between the words "health" and "nursing", insert the word "optometric,".
2. On page 2, line 2, between the words "hygienists" and "nurses", insert the word "optometrists,".
3. On page 2, line 19, after the word "hygiene", insert the word "optometric,".
4. On page 3, line 5, between the words "hygiene" and "nursing", insert the word "optometry,".
5. On page 5, line 11, after the word "enrollment" strike out the period and insert in lieu thereof a comma.
6. On page 5, after line 11, insert the following new paragraph:

"(6) to each school of optometry which provides training leading to a degree in optometry or an equivalent degree, $250 for each student enrolled for such training up to its average past enrollment, and $1,300 for each student so enrolled in excess of its average past enrollment."

7. On page 6, line 25, between the words "hygiene" and "nursing", insert the word "optometric,".
8. On page 8, line 15, between the words "hygiene" and "sanitary", insert the word "optometric,".
9. On page 13, line 12, between the words "hygiene" and "nursing", insert the word "optometry,".
10. On page 16, line 10, between the words "hygiene" and "nursing", insert the word "optometry,".
11. On page 22, line 14, between the words "hygiene" and "schools", insert the words "schools of optometry,".
12. On page 23, line 25, between the words "hygiene" and "nursing", insert the word "optometry,".
13. On page 25, line 2, between the words "dental" and "nursing", insert the word "optometric,".
14. On page 25, line 17, after the word "hygiene", insert the word "optometric,".

Are there any questions?

Mr. Biemiller. May I just observe, Doctor, that when I was a member of the Wisconsin Legislature, and I was handling health legislation there, I was always happy to have the very active cooperation of your State organization. I have the highest respect for the achievements that optometry has accomplished; and I am sure that we will look upon your recommendations very carefully and with good spirit.

Mr. Priest. Thank you, Dr. Ezell, and your complete statement has been included in the record.

The committee will stand adjourned until 10 o'clock tomorrow morning.

(Thereupon, at 1:20 p. m., the hearing was recessed until 10 a. m., Friday, June 10, 1949.)

NATIONAL HEALTH PLAN

FRIDAY, JUNE 10, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The committee will come to order. We are continuing today hearings on title I of H. R. 4312 and H. R. 4313 and also a related bill, H. R. 3894, introduced by Mr. Biemiller.

Our first witness will be Mrs. Eugenia K. Spalding.

STATEMENTS OF MRS. EUGENIA K. SPALDING, R. N., MEMBER OF LEGISLATIVE COMMITTEE, AMERICAN NURSES' ASSOCIATION, INC., DIRECTOR, DEPARTMENT OF NURSING EDUCATION, INDIANA UNIVERSITY, BLOOMINGTON, IND.; MISS BLANCHE PFEFFERKON, DIRECTOR OF STUDIES, NATIONAL LEAGUE OF NURSING, NEW YORK, N. Y.; MISS MARGARET G. ARNSTEIN, DIRECTOR, DIVISION OF NURSING RESOURCES, UNITED STATES PUBLIC HEALTH SERVICE, WASHINGTON, D. C.; MISS EDITH M. BEATTIE, CHAIRMAN, COMMITTEE ON FEDERAL LEGISLATION, AMERICAN NURSES' ASSOCIATION, INC., WASHINGTON, D. C.

Mrs. Spalding. Mr. Chairman, I am a member of the board of directors of the National League of Nursing Education, and a member of the American Nurses' Association, committee on Federal legislation, and director of the division of nursing education at Indiana University, Bloomington, Ind.

Some of the members of the American Nurses' Association committee on Federal legislation are here with me today, and with your permission, if there are questions that they can answer, because they are experts in their field, I would be very happy to call upon them.

Mr. Priest. Very well.

Mrs. Spalding. For the sake of brevity, and with your permission, I will omit certain statements, especially those giving statistics with which I know you are familiar.

The American Nurses' Association, which I am representing, is the national membership organization of graduate registered professional nurses in this country, having an enrolled membership of over 165,000.

It has a constituent association in each of the 48 States, the District of Columbia, Puerto Rico, and Hawaii. These constituent units are composed of approximately 500 district nurses' associations. The association was organized in 1896 and has been functioning actively ever since that date for the following purposes, to the end that the public may receive better nursing care:

> to promote the professional and educational advancement of nurses in every proper way; to elevate the standard of nursing education; to establish and maintain a code of ethics among nurses; * * * to disseminate information on the subject of nursing by publications in official periodicals or otherwise; to bring into communication with each other various nurses associations * * * of nurses throughout the United States of America * * *.[1]

The matter incorporated in the following paragraphs I will omit, but we would like to have it in the record.

Mr. PRIEST. Your statement will be included in full in the record, Mrs. Spalding.

Mrs. SPALDING. I believe you have copies of it.

Mr. PRIEST. We do have copies and your full statement will be included in the record, and the committee sincerely appreciates the fact that you will summarize it. I think that will be helpful to all of us.

Mrs. SPALDING. Thank you for including our full statement in the record, Mr. Chairman.

The testimony which I submit relates solely and entirely to title I of H. R. 4312 and to title I of H. R. 4313. It is the result of the deliberations of the six national nursing organizations over a period of nearly 2 years. The names of these organizations are given at the bottom of this page.[2]

During 1947 a statement of objectives concerning Federal aid to nursing education was drafted and approved by the national professional nursing organization. These objectives have been the platform of professional nursing with respect to Federal aid for nursing education. A summary of the objectives is attached as exhibit I.

It is our conviction that financial aid is needed for nursing education in order to provide both the quantity and quality of nursing service needed to maintain and to improve the Nation's health. This conviction is held irrespective of the form of health legislation that may be enacted.

First, we would like to point out that the so-called shortage of professional nurses is not due to a decrease in the number of available nurses but due to an expansion of the fields needing nursing service. Actually there were more professional nurses employed in 1948 than ever before. In hospitals and schools of nursing there were 230,059[3] employed in 1948 as against 149,407[4] in 1944. This increase was evident not in one but in all types of positions. Teaching and supervising personnel had increased by 3,095 or 14 percent; head nurses by 5,858 or 25 percent; administrative personnel by 2,912 or 44 percent; and full time general staff nurses from 56,766 to 104,041 or 83 percent.

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[1] Certificate of incorporation of American Nurses' Association, 1917.

[2] American Nurses' Association, National League of Nursing Education, National Organization for Public Health Nursing, Association of Collegiate Schools of Nursing, American Association of Industrial Nurses, National Association of Colored Graduate Nurses.

[3] American Medical Association, Hospital Service in the United States, 1949, p. 34.

[4] American Medical Association, Hospital Service in the United States, 1945, p. 781.

Another significant figure in the hospital field is the increase in general staff nurses in institutions conducting professional nursing schools. On January 1, 1949 54,500[5] of these nurses were reported; the largest number in prewar years was 29,100;[5] during the war it dropped to 18,000.[6]

In the public health field the number of employed nurses has also increased. In 1948, 22,600 public health nurses were employed; in 1944, 19,800.[7] In industrial nursing the number employed in 1948 was approximately 10,000,[8] compared with 9,400[9] the year previous.

One other set of figures that indicates the extent to which professional nursing has grown in the last two decades is the ratio of professional nurses—graduates and students—to population. In 1930 there was 1 nurse per 916 persons; in 1946 there was 1 nurse to every 316 persons.[10]

UNFILLED NEEDS IN NURSING

But still there are not sufficient professional nurses. The American Nurses' Association Professional Counseling and Placement Service reported that 5,169 positions were registered with it during 1948 and of these positions it filled 2,050, or 40 percent. All types of positions were included in those registered; 2,424 included various kinds of institutional positions, and of this number 855, or 35 percent, were filled. In the nursing education group only 20 percent of the positions were filled.[11]

Figures from the nurse counseling and placement office, New York State Employment Service, also show a relatively small proportion of positions filled. That office filled one-third of the institutional positions (staff, teaching, and supervisory) registered with it and approximately one-half of the positions in the public health nursing field.

A large university operating a placement bureau[12] reported that for 323 positions as teachers and supervisors in schools of nursing and hospitals it was unable to fill 209 or 65 percent; and of 158 public-health positions—including staff, supervisors, administrators, and teachers—it was unable to fill 82, or 52 percent.[13]

The Division of Nursing of the Public Health Service has made State-wide studies of nursing needs and nursing resources in different areas of the country in the last several years. Every study made showed there were not enough professional nurses.

In one large Eastern State the available number of professional nurses was 45,000, whereas at least 55,000 were needed. In two Southern States the needs for professional nurses exceeded supply by 1,500 and 2,500 respectively. A similar situation existed in a far Western State, the available number of professional nurses being 3,350, and the number needed 4,600.[14]

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[5] National League of Nursing Education, Department of Studies, unpublished data, 1949.

[6] American Journal of Nursing, June 1948, p. 400.

[7] American Nurses' Association, 1948 Facts About Nursing, p. 21.

[8] American Association of Industrial Nursing, November 1948, p. 7.

[9] American Nurses' Association, 1948 Facts About Nursing, p. 24.

[10] American Nurses' Association, 1948 Facts About Nursing, p. 15.

[11] While inability on the part of any placement service to fill positions may be due to lack of applicants both in number and qualifications, it may also be due to other causes. Among such possible causes are poor personnel practices of the employer, family responsibilities, and other factors which make it impossible or undesirable for applicants to go to localities where vacancies exist.

[12] Teachers College, Columbia University, 1947–48.

[13] While inability on the part of any placement service to fill positions may be due to lack of applicants both in number and qualifications, it may also be due to other causes. Among such possible causes are poor personnel practices of the employer, family responsibilities, and other factors which make it impossible or undesirable for applicants to go to localities where vacancies exist.

The need for professional nurses, both in numbers and qualifications, is further indicated by the following facts. In 1948 there were 1,050 counties in the United States without any public health nursing service.[15] Psychiatric hospitals have never had the number of professional nurses they need to give their patients the proper care. In 1948 there was one professional nurse to every 75 patients, and included in that ratio are administrators, supervisors, head nurses, and general staff nurses. As a matter of fact, if only general staff nurses are considered, the ratio is 1 professional nurse to every 245 patients, a shockingly low provision for professional nursing care.[16] Even though nurses are the largest single group of health workers in the Nation there are not enough.

WHY THERE ARE NOT ENOUGH NURSES

The question might well be asked, "Why with the large and growing army of professional nurses is there the wide gap between supply of nurses and need for nurses?" At the risk of citing information which is already well known to this body we list the following factors:

1. Expansion of group hospitalization resulting in an increasing number of persons enjoying hospital services.

2. Expansion of hospital facilities. Each time a hospital is enlarged or a new one built an increase in the hospital personnel follows. Of this personnel, nurses constitute a considerable number.

3. Increase in the number of health agencies employing public-health nurses. In 1948 there were 326 more such agencies than in 1947.[17]

4. New developments in medical science and practice requiring expanding and new nursing services.

5. Expansion of the nursing service of the Veterans' Administration and the Army and Navy Nurse Corps.

6. Increasing number of persons in need of medical treatment and nursing care due to the increased life span and the complex conditions of modern living.

7. International health obligations. War and the aftermath of war have created vast problems of health and rehabilitation in Europe and Asia. People in those countries are looking to the United States for medical and nursing services in order to rebuild the minimum conditions for living a useful and healthy life.

8. Social and health legislation. At least 16 bills have bene introduced by the Eighty-first Congress that include provisions which require widely expanded nursing personnel for implementation. Each time a legislative measure is enacted for the purpose of improving the health of the Nation—and many such have been enacted since 1932—implicit in the enactment is the need for more nursing personnel.

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[14] Federal Security Agency, Division of Nursing, Public Health Service, 1945, 1948.
[15] American Nurses' Association, 1948 Fact About Nursing, p. 23.
[16] American Medical Association, Hospital Service in the United States, 1949, p. 34.
[17] American Nurses' Association, 1948 Facts About Nursing, p. 23.

NOT ONLY MORE BUT BETTER QUALIFIED NURSES NEEDED

While the chief emphasis of the data submitted thus far has been on quantity needs, substantial evidence exists to support equally pressing need in quality.

In 1948 there were 22,600[18] nurses employed by public health nursing agencies in this country. Approximately one-third[19] only of these nurses were qualified in terms of public health nursing education, leaving 15,000 who were inadequately prepared and had to do their jobs as best they could.

In the fields of hospital nursing and nursing education the qualifications of nurse personnel are no better than in public-health nursing. There were 50,000[20] administrators, teachers, supervisors, and head nurses in hospitals and basic schools of nursing in 1948. Probably at least 30,000 of that number had no special educational background for their highly specialized functions.

To get nurses in the field with the specialized preparation needed for their specialized functions, it becomes imperative to have a sufficient corps of nurse educators, who are comparable to the "teacher training" group in general education. At the moment the number of such qualified personnel is woefully inadequate. It was very serious before the war and during the war it was aggravated and now even with increases it is very serious.

It may seem paradoxical while urging an increase in the number of nurses, to press forward the need for an over-all improvement of the profession. For the protection of the public we cannot conscientiously advocate the recruitment and training of large numbers of students in schools of nursing unless we have an adequate number of well-qualified nurse administrators, supervisors, and teachers.

REPORT ON NEED TO THE PRESIDENT'S COMMISSION ON HIGHER EDUCATION

The report submitted to the President's Commission on Higher Education estimated that 400,000 nurses would be needed by 1950.[21] These 400,000 were professional nurses.

With the expanding demands for the services of professional nurses, the need for enlarging the trained practical nursing group is increasingly being stressed. Once any considerable number of practical nurses who have had a course of instruction and experience in an accredited practical nursing school is available, that group will provide a valuable auxiliary nursing service to supplement the service of professional nurses. At present, however, there are only 13,300 trained practical nurses in this country.[22]

In 1948 there were less than 300,000[23] active professional nurses. With an estimated need of 400,000 this leaves a gap of 100,000.

I would like to emphasize here that this number includes those graduating from the diploma program and also those graduating from the degree program.

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[18] American Nurses' Association, 1948 Facts About Nursing, p. 21.

[19] Federal Security Agency, Public Health Service, 1948.

[20] American Medical Association, Hospital Service in the United States, 1949, p. 34 (with adjustment in hospital nursing classification, using 50 percent of head nurses and assistants reported).

[21] Estimate of the Need for Professional Nurses, 1947–60, prepared for the President's Commission on Higher Education.

[22] National League of Nursing Education, Department of Studies, Special Study of Schools of Practical Nursing.

[23] American Nurses' Association, 1949 Facts About Nursing, p. 13.

As the number of trained practical nurses increases, this gap should tend to disappear. Irrespective of whether we need 100,000 or 50,000 more professional nurses, the need is sufficiently great to rouse concern and action.

How many trained practical nurses can profitably be absorbed we do not know and cannot know until more of that group are available to set up experimental services in each different type of hospital. But certain it is that we need many more than we now have. A target should be set for producing at least 50,000 within the next 5 years.

FINANCIAL NEEDS IN UNIVERSITY SCHOOLS OFFERING ADVANCED TRAINING

The facts concerning nursing are these:

(1) The needs for nursing personnel in a comprehensive national health program have increased beyond the present national facilities for preparing such personnel.

(2) The needs for personnel include both professional and trained practical nurses.

The expanded training of personnel, both professional and practical, can only be accomplished by increasing the number of competent personnel responsible for such training. Unless this can be done, standards cannot be maintained, and the result will be a lowering of the quality of the nursing service of the Nation.

Competent personnel responsible for the training of nurses include those functioning in nursing service[24] as well as nursing education. Such personnel include in the nursing-service field, administrators, supervisors, head nurses, and clinical specialists, and, in the nursing education field administrators of training programs—basic and advanced and practical-nurse training programs—teachers of the different curriculum subjects in each type of program and supervisors of practical-nurse training in vocational education on the National and State level. In addition to the personnel required for operational programs there are also needed workers trained in the techniques of research and experimentation.

Mr. PRIEST. It is usually against our procedure to interrupt a witness, but in order to clear one little matter in my own mind, before you proceed, I want to ask you one question.

You refer on page 5 to 300,000 nursese in 1948 and you referred to them as diploma and degree nurses.

Now, is the diploma nurse a practical nurse?

Mrs. SPALDING. The diploma nurse is one prepared in the hospital schools of nursing.

Mr. PRIEST. I understand, and I just wanted to clear that in my own mind. Thank you. I apologize for interrupting your statement.

Mr. SPALDING. In continuing, we would like to say that in addition to the personnel required for operational programs, there are also needed workers who are trained in the techniques of research and experimentation.

To prepare the nursing personnel needed in all types of nursing schools, universities offering such preparation need financial aid. The extent to which they need this help is indicated by information secured recently from 16 representative universities providing advanced training in nursing.[25]

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[24] Nursing is learned by experience and participation in actual nursing service situations. A good educational program presupposes a good nursing service situation where students learn to nurse, which in turn presupposes well-qualified persons directing and supervising nursing service.

Nine of the 16 reported they needed additional faculty members either to improve their present programs or to admit more students or both.

Five stated they needed clinical practice fields—a facility which is generally considered a highly expensive item in the advanced training program.

Five also stated they needed more classroom and laboratory space and one university referred to the "cost of building construction."

Five stated specifically they could not admit more students with present facilities.

Seven of the 16 universities reported that they could not secure their needed faculty and facilities because of lack of funds. Twelve of the 16 universities listed programs which they are not now offering but which they should be offering. Seven stated they could not develop these programs because of "lack of funds"; six because they were unable to secure the necessary faculty. The faculty limitation seemed to be tied up with finances in some instances, in others with lack of qualified personnel.

The programs named most often as additional ones that should be offered are those that require clinical-practice facilities—a highly expensive facility in an advanced training program. Ten such programs were listed.

There are 62 universities offering advanced training programs.[26] Since the 16 universities from which the above information was secured include a representative group among such institutions, it is highly probable that their financial limitations either to improve their present programs or to train more students are repeated in the other 46.

At the present time a large proportion of the recently initiated advanced clinical programs which include field experience are financed almost entirely through sources outside the institutions.

The evidence indicates emphatically the need for financial aid to improve the now existing advanced-training programs, to develop new programs, and to provide the funds essential for equipment and construction of new schools and the expansion of existing ones.

FINANCIAL NEEDS IN UNIVERSITY SCHOOLS OFFERING BASIC TRAINING

In this country there are approximately 1,215 basic schools of nursing.[27] Of this number less than 100 or 8 percent are schools which are college or university controlled and offer training leading to a baccalaureate degree. These schools, of course, bear a large share of the responsibility for the education of the future leaders of the nursing profession.

Recent information received from a representative group of these collegiate basic schools indicates that they too are in need of financial aid if they are to expand their student body.

For example, one school reports that it needs more faculty, classrooms and laboratories, and clinical-practice fields, and also enlarged residence and library accommodations. Other schools report either need for increased faculty or one or more of such facilities as residence, library, classrooms and laboratories, and clinical-practice fields. Almost uniformly the inability to secure faculty and facilities is explained by lack of funds, rising cost of construction, and lack of qualified personnel.

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[25] National League of Nursing Education, Department of Studies, Special Study.

[26] National League of Nursing Education, Programs for Graduate Nurses Leading to a Degree in Universities and Colleges, 1948.

[27] National League of Nursing Education, 1949 Supplement to 1946 State-Accredited List.

At a 2-day conference of authorities on nursing education in December 1948, the urgency of expanding the facilities of university basic schools and establishing new ones was constantly stressed. It was pointed out again and again that professional nursing cannot meet its responsibilities in a world where all people—not just a few—enjoy health care and health teaching unless the number of nurses who have had a broad training—both general educational and professional—as given in a collegiate school are steadily increased. Then there will be more of the better qualified nurses to go into the homes to teach the tuberculosis patient health measures, to promote his recovery, and protect his family and community from contracting the disease; then there will be more of the better-qualified nurses to play their roles in preventing mental illness and in caring for and helping the patients in the mental hospitals to recover. Then, too, there will be more nurses who appreciate what they can do in the rehabilitation movement which has made such strides since World War II. It takes knowledge, art, and patience to help the patient who has had a cerebral hemorrhage to learn to talk again; to help the man who has lost his sight to regain some peace and some security in his new shut-out physical world.

But collegiate schools of nursing can grow only if they have the necessary funds. It is difficult to secure figures on the per capita cost of nursing students to the university, partly because universities usually do not segregate the costs of students enrolled in the different programs and partly because nursing education costs are complicated by costs inherent in giving the student hospital experience. It is, however, a well-known fact that student fees in a university do not meet the actual cost of education. In 1947 student fees in universities and colleges met only 56 percent of their total educational expenditures. Approximately 30 percent of that 56 was provided by payments of the Federal Government to veterans. In 1940, student fees covered less than 40 percent of total educational expenditures of those institutions.[28] Universities or colleges without financial aid are not likely to find themselves able to initiate basic training for nurses or to expand their programs in places where such programs exist.

HOSPITAL SCHOOLS OF NURSING

Of the 1,215 existing State-accredited schools of nursing approximately 1,125 are hospital operated and controlled schools.[29]

The student enrollment in these schools ranges from the very small school with 5 students to the very large with 464 students. The size of hospitals operating schools varies all the way from a daily average census of 16 patients to a daily average of 2,926.[30]

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[28] Federal Security Agency, Division of Higher Education, Circular 236, table 2, May 26, 1947.

[29] National League of Nursing Education, Department of Studies, unpublished data, 1949.

[30] National League of Nursing Education, Department of Studies, unpublished data, 1948.

There are some excellent hospital schools of nursing; it is safe to say there are many more mediocre and poor hospital schools.

An excellent or very good hospital school may be a financial liability to the hospital. A mediocre or poor hospital school will in all probability be a financial asset to the institution. During the period 1944–45, the Public Health Service made cost analyses in about 45 hospital schools of nursing. The findings of that study showed that, in general, the fees paid by students plus the financial value of their service to the hospital more than offset the total cost to the hospital of training and maintaining the students.[31]

In another study of nursing education costs, costs were studied in three hospitals schools, all three of which were generally regarded as good schools.

In one of the three, the annual net contribution per student to the hospital was $41.81, in another $81.35, and in the third $241.40. The total net contribution by these schools to their respective hospitals for the year was $2,675, $10,251, $21,146. These contributions, which took into account both the fees paid by students and the service they rendered in the process of learning nursing, were over and above any expense incurred by the hospitals in the conduct of their schools.[32]

It is not intended to imply that all hospital schools are financial assets to their associated hospitals. Many factors affect costs. One important factor is the size of the school; another is the breadth of the program, particularly with reference to the inclusion of such experiences as psychiatric nursing, tuberculosis, and other specialized services. And, as you know, these are lacking all over the country at the moment.

Certainly for some years to come, pending the expansion of collegiate basic programs and an increase in facilities for training practical nurses, the hospital school must be looked to for providing most of the nursing personnel needed—in 1948, 34,268 [33] professional nurses were graduated and of that number 1,215 [34] were graduated from collegiate schools and received their baccalaureate degrees.

It would seem urgent, therefore, at the present time, to give deliberate and careful consideration to hospital schools in any broad national health program. Those schools that show promise should be given financial aid to improve and broaden their training, and conversely financial aid should be withheld from those that do not.

PRACTICAL NURSE TRAINING

No consideration was given in the "Objectives" to Federal aid for practical nurse training. In the meantime it has become evident that such aid is highly desirable; and the national nursing organizations are agreed that there is an immediate and urgent need to organize a large number of practical nurse training schools under the auspices of vocational education. It is desired to point out, however, that there are no provisions in H. R. 4312, title I, and in H. R. 4313, title I for professional nurse direction of the practical nurse program in the

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[31] Federal Security Agency, Division of Nursing, Public Health Service, Cost Analyses in 45 Schools of Nursing, 1944–45.

[32] American Hospital Association and National League of Nursing Education, Administrative Cost Analysis for Nursing Service and Nursing Education, 1940, p. 103.

[33] American Journal of Nursing, March 1949, p. 182.

[34] National League of Nursing Education, department of studies, unpublished data, 1949.

Office of Education of the Federal Security Agency. It is hoped, as the practical nurse training program progresses, that (1) professional nurse direction of practical nurse training will be provided in the Office of Education, and (2) that the activities concerning practical nurse training will be coordinated with professional nursing education as administered by the Public Health Service.

On January 1, 1949, only 71 schools of practical nursing were in existence. During 1948, 3,000 students were admitted to 71 schools and 1,600 graduated. Although 13,300 practical nurses were reported to have been graduated from these schools.[22]

It has already been stated that we should aim at producing 10,000 practical-nurse graduates annually for the next 5 years. To graduate this number, it would probably require the annual admission of at least 15,000 allowing for withdrawal during the training period. Every possible recruiting measure will certainly need to be devised to bring up the admissions from 3,000 to 15,000. Practical nurses, trained properly furnished a valuable supplementary nursing group to professional nursing personnel, thus increasing the nursing service of the country.

In this connection, we would like to point out that the net effect of page 36, line 14, through page 37, line 11, and page 41, lines 7 to 13 of the bill, would appear to restrict the benefits to private nonprofit institutions to a much narrower range than those available to public institutions. Until there is further clarification available, we are unable to comment. We have asked for clarification of this language.

NEED FOR STUDENT FINANCIAL ASSISTANCE

Student financial assistance is needed to secure the number of candidates needed in nursing. This is particularly true of applicants to college or university schools, both those offering basic and those offering advanced training programs.

Fourteen of sixteen university schools offering basic training reported they could take more students. The expense to the student for the entire program, including tuition, fees, other expenses, and maintenance, in college- and university-controlled schools in 1946 ranged from—and this is a different statement than you have—ranged from less than $100 in a State university to $3,135 in a private college;[35] and it is a well-known fact that educational fees have risen since then. The school in which students paid $3,100 for a 4-year program in 1946 reported that the cost to a student for the program in 1948 was $4,625. It seems highly probable that more students would go to these schools were they financially able.

I believe I should indicate here that these figures refer to the entire programs rather than the per year costs.

When a graduate nurse goes to a university to secure advanced training she is giving up the opportunity to earn for the period, and at the same time she is incurring educational expenses. Both college fees and living expenses are now at their all-time high. Many graduate nurses cannot afford a full time advanced training program, even though they are capable of and eager to undertake it.

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[22] National League of Nursing Education, Department of Studies, Special Study of Schools of Practical Nursing.

[35] National League of Nursing Education, State-Accredited Schools of Nursing, 1946.

In the fall term of 1948, there were 11,600 students enrolled for advanced training programs; 4,700 of that number were full-time students; 6,900 were part time.[36] It is a reasonable assumption that all or at least the majority would have been taking a full-time program had they been able to give up earning during the year or more necessary for them to complete their university work.

CONSIDERATION OF H. R. 4312, TITLE I, AND H. R. 4313, TITLE I

At a meeting of representatives of the six national nursing organizations in April 1949, the principle of securing financial assistance for nursing education through a Federal act providing such assistance for all health professions was unanimously approved.

There are, however, certain differences in the provisions of title I, H. R. 4312, and of title I, H. R. 4313, and the "objectives" previously referred to. We respectfully submit to the House Committee on Interstate and Foreign Commerce the fundamental of these differences, which will inevitably affect the quality of the nursing service rendered to the Nation.

Title I, H. R. 4312, and title I, H. R. 4313, make no provisions for much-needed research and experimentation in nursing education and nursing service in hospitals and other institutions for public health. Now that there is concerted national effort to increase the number of trained practical nurses we need experimentation in the conditions under which they can work most effectively. We urgently need studies to find out the sound numerical relationship of professional and practical-nurse personnel. Another important type of study needed is that concerned with basic and advanced nursing curricula.

Title I, H. R. 4312 and title I, H. R. 4313 make no provisions for a commission on policies and regulations. The Surgeon General has full power to prescribe all regulations, after consulting with the National Council on Education for Health Professions. The Council appears to be merely advisory in character.

Attached to this testimony is a list of recommended amendments to title I, H. R. 4312 and title I, H. R. 4313—exhibit II. The amendments will, it is believed clarify certain provisions in the bills and assure their proper interpretation and in addition strengthen the administration of the act and particularly when page 33, line 10, includes Alaska, Hawaii, Puerto Rico, and the Virgin Islands within the benefits of the program for practical nurse training.

In addition to these amendments we wish to bring before the committee certain questions relating to the provisions for financial aid to schools and provide basic training leading to a diploma in nursing—section 372 (b) (3) (B) of title I, H. R. 4312 and of title I, H. R. 4313.

There is no provision which requires a graduate of a school offering basic training leading to a diploma to remain in practice for a specific period of time after graduation.

We realize, of course, that such a provision might have been very difficult to enforce.

There is no provision which prevents a diploma student from withdrawing at any point in her training without obligation on her part for the training which has been made available to her without charge.

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[36] American Journal of Nursing, March 1949, p 181.

Thirty-nine percent of the students in the class of 1947 and also in the class of 1948 withdrew before they completed their training. Since 1938 approximately 30 percent of the students admitted withdrew from each class before graduation. This loss from student withdrawals would be costly to the Government.

There is no bonus for the hospital school which increases its student body nor is there a bonus to stimulate the hospital school to increase its enrollment. We question this plan, assuming that the list of schools of nursing approved by the Surgeon General for Federal aid will include those schools which should expand their enrollment.

We raise the question whether it is the purpose of this clause, section 372 (b) (3) (B), to subsidize all students or whether a school may admit a student who wishes to pay her own tuition and other expenses and allow her to do so.

We question whether the present provision in section 372 (b) (3) (B) will (1) help to improve the nursing services of the country, and (2) provide the number of nurses necessary for the health services of the Nation by stimulating enrollment in those schools able to prepare well quaified nurses and by holding nurses in active practice after graduation.

Finally we ask whether it would not be wiser to follow in general the same plan for the schools offering basic training leading to a diploma in nursing as that provided for other nursing schools and allot to those diploma schools $150 for each student enrolled in such training up to its average past enrollment, and $400 for each student so enrolled in excess of its average past enrollment, at the same time permitting the school (1) to continue to charge for tuition and other items of expense, (2) to use the funds allotted under this section for added instructional costs and scholarship aid, the scholarship aid not to exceed 50 percent of the total allotment, and (3) to obligate the student for service proportionate to the period of time for which the aid was received.

(The data above referred to is as follows:)

EXHIBIT I

SUMMARY OF OBJECTIVES CONCERNING FEDERAL AID FOR PROFESSIONAL NURSING EDUCATION

(Prepared by a committee of the National League of Nursing Education, January 1948)

1. *Purposes of professional nursing education*

(*a*) Provision of professional nursing personnel qualified to render a high quality of service in the curative, preventive, and health fields of nursing.

(*b*) Provision of administrative and instructional personnel for the broad training of professional nurses as described in (*a*).

2. *Types of professional nursing education essential to fulfill the nursing needs society*

(*a*) Broad general education and experience, including social sciences and the physical and biological sciences with great emphasis on the humanities and nursing arts.

(*b*) Preparation of nurses for all types of community nursing service and for administrative and instructional responsibilities in conducting nursing education programs, basic and advanced.

In order to prepare nursing personnel as described in (*a*) and (*b*), instruction should be coordinated with general education, public and private.

3. The public's stake in nursing education

The public should assume some responsibility for the cost of nursing education, since the welfare of the public is affected by the quality and quantity of nursing service rendered.

4. Status of Federal aid to nursing education

A study made in 1947 revealed that the major portion of Federal funds available for nursing education has been granted for scholarships for graduate nurses with the exception of funds allotted to the United States Cadet Nurse Corps program and in connection with the Social Security Act.

5. Proposed purpose of Federal aid for nursing education

Improvement of professional nursing service through the improvement of programs of professional nursing education, basic and advanced.

6. Proposed uses of Federal aid for nursing education

(*a*) National studies to determine qualitative and quantitative nursing needs.

(*b*) Preparation of skilled nurses for general staff in hospitals and other community agencies and for private practice.

(*c*) Preparation of educational, administrative, and instructional personnel for nursing service in hospitals and other community agencies and for institutions offering basic and advanced nursing education.

(*d*) Provision of educational equipment.

(*e*) Temporary demonstrations, intensive courses and workshops in nursing education.

(*f*) Research in administration of program and publication of findings.

7. Types of instructions suggested to receive Federal funds

Both those that are publicly and those that are privately supported.

8. Types of nursing programs for which Federal aid should be sought

Basic and advanced professional nursing curricula, regardless of race, creed, or color, of controlling institutions.

9. Federal aid for scholarships

For students in advanced nursing programs.

10. Suggested Federal agency for administration of funds

The committee believes it is not within its province to name the Federal agency. It was the concensus, however, that such agency or organizational unit thereof should be one whose primary purpose is higher education.

11. Regulation and policy-forming group

A civilian commission to include members of the nursing profession: Approximately two-thirds of the commission should be professional nurses nominated by six professional nursing organizations participating in the national structure study.

Functions of the commission (1) to serve as a regulation and policy-forming body, (2) to act in an advisory capacity to the nursing and other technical personnel responsible for administering the funds.

12. Distribution of Federal funds for nursing education

Go directly to approved institutions from the Federal agency administering the Federal funds.

13. General principles concerning Federal aid to nursing education

(*a*) Must not result in direct Federal control of any nursing education program. Federal statute should state plainly the purposes for which funds are to be used and also that the only Federal interest is to see that the money granted is used for these purposes.

(*b*) Role of Federal aid secondary and supplementary to aid from private sources and States.

(*c*) Regulations and policies set up by proposed commission not to interfere with educational and nursing service experimentation in individual institutions.

Role of national nursing organizations

(*a*) Suggest policies to guide legislators in drafting Federal legislation for nursing education.

(*b*) Develop and publish nursing service and nursing education standards to guide in developing or checking regulations and in solving problems in the administration of Federal funds.

(*c*) Study and influence passage or defeat of Federal legislation for nursing education.

(*d*) Nominate members for commissions and advisory and technical committees for Federal nursing education programs.

(*e*) Keep their membership informed on matters pertaining to Federal legislation.

(*f*) Prepare testimony on Federal legislation concerning nursing education.

Role of State nursing organizations

(*a*) Point out local and State nursing educational needs and make suggestions to national nursing organizations concerning educational policies and standards.

(*b*) Keep membership informed on Federal legislation concerned with nursing education.

(*c*) Inform United States Senators and Congressmen representing their respective States of desirable and undesirable legislation for nursing education.

EXHIBIT II

RECOMMENDED CHANGES IN BILLS H. R. 4312 (TITLE I) AND H. R. 4313 (TITLE I)

Page 11, line 23 through page 12, line 3:

As stated in bill: "by giving financial assistance for the construction and equipment of new schools and the expansion of existing schools, with a view to providing opportunities for more qualified individuals to obtain such training regardless of their race, creed, color, or national origin."

Recommended change: Insert "sex" before "creed".

Reason for recommendation: In order that schools training men nurses might receive the benefits provided in the bill.

Page 13, lines 16–21:

As stated in bill: "(3) to each school of nursing (A) which provides basic or advanced training leading to a degree in nursing, $200 for each student enrolled for such training up to its average past enrollment, and $1,200 for each student so enrolled in excess of its average past enrollment;"

Recommended change: "(3) (A) to each university—or college—controlled school of nursing that provides basic or advanced training in nursing for which it grants a baccalaureate or higher degree, $200 for each student enrolled in such training up to its average past enrollment, and $1,200 for each student so enrolled in excess of its average past enrollment;"

Reason for recommendation: There are some hospital-controlled schools of nursing operating basic programs which have arrangements with colleges or universities, whereby the colleges or universities grant credit for the hospital-school programs toward a degree, although the hospital-school programs are not controlled by the colleges or universities. Such schools properly fall under the classification of (3) (B) page 13, line 21 to page 14, line 4, since the intent of (3) (A) would appear to be to provide financial assistance to schools of nursing controlled by universities and colleges. Universities and colleges offering basic or advanced training in nursing may grant degrees in nursing or other degrees on a baccalaureate or higher level; and all such training and degrees should be included in the coverage of the bill.

Page 16, line 1:

As stated in bill: "first semester".

Recommended change: Substitute "first regular term" for "first semester".

Reason for recommendation: All universities do not operate on the semestral plan.

Page 22, lines 14–17:

As stated in bill: "In order further to increase the number of persons adequately trained in the fields of medicine, dentistry, dental hygiene, nursing, public health, including hospital administration and sanitary engineering * * *"

Recommended change: Insert "(including refresher training)" after the word "trained".

Reason for recommendation: It is believed that scholarship assistance should be awarded to persons taking "refresher training". In S. 1453, provision for such assistance is made.

Page 23, lines 20–22:

As stated in bill: "(4) scholarships to schools of nursing providing basic or advanced training leading to a degree in nursing;"

Recommended change: Insert "university- or college-controlled" before "schools"; insert "baccalaureate or higher", before "degree"; delete "in nursing" at end of clause.

These lines will then read: "(4) scholarships to university- or college-controlled schools of nursing providing basic or advanced training leading to a baccalaureate or higher degree;"

Reason for recommendation: To conform with changes recommended, page 13, lines 16–21.

Page 25:

Recommended insertion: Insert in section 378. (a) between (2) and (3): "Provide for the establishment or designation of a State advisory committee for each of the fields and composed of representatives of the respective fields of medical, nursing, dental, dental hygiene, sanitary engineering, and public health education which may advise the State agency in the formulation and administration of a plan and shall assist the State agency in the selection of appointees for scholarships.

Reason for recommendation: Such State advisory committees will be informed of the qualifications needed or desirable in prospective students to insure success in their studies and in their respective professions.

Page 26, line 2:

Recommended change: Insert "sex" after "creed".

Reason for recommendation: It is believed that there should be no discrimination because of sex in awarding scholarships.

Page 28, lines 4–7:

As stated in bill: "(b) agreement by the appointee to serve, upon completion of his training (including internships and residencies) one year for each two academic years during which he received the benefits of the scholarship.

Recommended change: Insert after parenthetical phrase "(including internships and residences)" the words, "in the practice of his profession with respect to which said scholarship was granted." The clause will then read: "(b) agreement by the appointee to serve, upon completion of his training (including internships and residencies) in the practice of his profession with respect to which such scholarship was granted, one year for each two academic years during which he received the benefits of the scholarship."

Page 28, lines 7–16:

Recommended change: Insert period after "scholarship" in line 7 and delete remainder of line 7 and lines 8 through 15 and the word "States" in line 16.

Reason for recommendation: We believe that the provisions contained on page 28, (i) (ii), lines 7–16, are directly contrary to American traditions and would defeat the purpose of the bill.

Definitions:

Recommended addition: Insert definitions contained in S. 1453, Sec. 384. Add another definition (c) to read as follows: "(c) The term 'school' includes divisions, departments, and other administrative units in hospitals, colleges or universities, and also independent schools."

Reason for recommendation: These definitions are important in interpreting terms. With reference to definition (c), educational programs in nursing may be offered by departments or divisions of universities or hospitals. For example, a basic school of nursing may be a department in a hospital.

Page 32, lines 1–6:

As stated in bill: "The twenty appointed members [of the National Council on Education for Health Professions] shall be leaders in the field of medical sciences, education, or public affairs, and ten of the twenty shall be selected from leading authorities in the field of medical, dental, nursing, sanitary engineering, and public health education."

Recommended change: Break up sentence into two sentences, omitting "and" after "public affairs" and changing comma to period. Substitute "at least three" for "ten." Change "authorities in the field" to "authorities in each of the fields." Insert "respectively" after "education" at end of sentence. With those changes, the sentence will read: "The twenty appointed members shall be leaders in the field of medical sciences, education, or public affairs. At least three of the twenty shall be selected from leading authorities in each of the fields of medical, dental, nursing, sanitary engineering, and public health education respectively."

Reason for recommendation: To insure at least three representatives on the National Council on Education for Health Professions from the field of nursing education.

PART B OF BILLS H. R. 4312 (TITLE I) AND H. R. 4313 (TITLE I)

CONCERNED WITH PRACTICAL NURSE TRAINING

Page 33, beginning line 22 and with omissions to page 34, line 25.

As stated in bill: "To be approved under this part, a State plan for practical nurse training must provide * * * (6) for the availability of professional education courses necessary for the certification of teachers, supervisors, and directors of practical nurse training; (7) that such training leading to certification of teachers, supervisors, and directors shall be given under the auspices of the State board [for vocational education] and, except in the case of teachers of related subjects, only to persons who have had adequate experience in nursing;"

Recommended change: Delete all of (6) and all of (7).

Reason for recommendation: Courses preparing professional nurses as teachers, supervisors, and directors of practical nurse training should be made available in schools of nursing and other administrative units of universities offering advanced training to professional graduate nurses. Such courses are already in existence and under the direction of a professional nursing group conversant with the function and educational needs of professional nursing personnel engaged in practical nurse training. Provision for the preparation of teachers, supervisors, and directors of practical nurse training in such courses is made on page 13 of this bill.

Page 33, beginning line 22 and with omissions to page 35, line 3:

As stated in bill: "* * * a State plan for practical nurse training must provide * * * (8) duties and qualifications for teachers, teacher-trainers, supervisors and directors, and plans for the supervision and direction of practical nurse training;"

Recommended change: Delete "teacher-trainers."

Reason for recommendation: Professional nursing personnel receive their preparation for teaching, supervising, and directing practical nurse training in nursing administrative units in universities. The faculty of such units constitute the "teacher-trainer" group for practical nurse training.

Page 33, line 22 and with omissions to page 35, line 7:

As stated in bill: "* * * a State plan for practical nurse training must provide * * * (9) for an advisory council composed of not more than ten nor less than six persons, including not less than two registered nurses, a physician, and educator, a hospital administrator, and such other persons the State may, desire, * * *."

Recommended change: Insert "professional" after "registered"; insert "a practical nurse (who shall be a licensed practical nurse, if the State in which she practices shall have provided for the licensure of practical nurses)" before "a physician." With these changes the above lines will read as follows: "* * * a State plan for practical nurse training must provide * * * (9) for an advisory council composed of not more than ten nor less than six persons, including not less than two registered professional nurses, a practical nurse (who shall be a licensed practical nurse if the State in which she practices shall have provided for the licensure of puractical nurses), a physician, an educator, a hospital administrator, and such other persons the State may desire, * * *.

Reason for recommendation: This recommendation is made in the belief that practical nurses should be represented on a State advisory council on practical nurse training, inasmuch as a qualified practical nurse could make a valuable contribution to the work of such council.

Page 36, lines 14–17:

As stated in bill: "(c) The funds appropriated * * * may be used * * * in meeting the direct costs of maintaining an adequate program of administration, supervision, and teacher-training;"

Recommended change: Delete "and teacher training."

Reason for recommendation: Given in first recommendation.

Page 36, line 14 and with omissions to page 37, line 11.

As stated in bill: "(c) The funds appropriated * * * may be used * * * for paying the cost of practical nurse training, under the supervision or control of the State board or local boards of vocational education, in public or nonprofit private hospitals exempt from income tax under section 101 of the Internal Revenue Code:"

Recommended change: Insert "clinical" before "training."

Reason for recommendation: As the statement is written in the bill it would appear that it could be interpreted to mean that the entire practical nurse training program could be carried on in public or nonprofit hospitals, under the supervision or control of the State board or local boards of vocational education. The statement properly refers to the clinical part of training only. By inserting "clinical" correct interpretation is assured.

Page 38, lines 21–24:

As stated in bill: "(c) Funds appropriated pursuant to this part shall not be paid to any State until a State supervisor of practical nurse training meeting the minimum requirements established in the State plan has been employed."

Recommended change: These lines to read as follows: "(c) Funds appropriated pursuant to this part shall not be paid to any State until a registered professional nurse has been appointed as a State supervisor of practical nurse training who shall meet the minimum requirements established in the State plan."

Reason for change: For the sound development of practical nursing in the several States it is essential that the State supervisor be a registered professional nurse. The registered professional nurse will not only be aware of the problems in practical nurse training but also of the articulation of practical nursing in the total nursing field.

Mrs. SPALDING. In closing, Mr. Chairman, may I express to you and to the members of the committee the appreciation of the nursing profession for the privilege of presenting this statement, which is based upon the results of a serious and realistic study of the present nursing situation, and these bills, relative to nurse training and its relation to the training of personnel in the other health professions.

We also wish to express our willingness to assist your committee further in any way in our power to secure Federal legislation which will improve health services in all its aspects.

We believe that title I of these bills has many desirable features, and that with certain suggested changes would serve as a basis for Federal aid to all of the health professions.

Mr. PRIEST. Mrs. Spalding, I want to thank you so much on behalf of the committee. I feel certain that I can express to you our thanks and our deep appreciation for the presentation of a very fine, and one of the best documented statements that has come before this committee.

Your statement indicates a great deal of preparation, of study from source material, information gathered and gained, in conferences, and we do appreciate it very much.

I may have one or two questions later on, but, for the time being, we will pass the questioning to other members of the committee. Mr. Sadowski, do you have any questions?

Mr. SADOWSKI. Not at this moment.

Mr. PRIEST. Mr. Biemiller?

Mr. BIEMILLER. Yes, Mr. Chairman, I would like to pursue further a point that is raised on page 8, and also refer back to page 3 of Mrs. Spalding's statement.

On page 8, you state that there were 34,268 professional nurses graduated and that of that number 1,215 were graduated from collegiate schools and received their baccalaureate degrees.

I believe in round numbers there are now around 300,000 nurses in the United States. Is that correct?

Mrs. SPALDING. That is correct.

Mr. Biemiller. If that is true, then that is something over 10 percent of those graduated in 1948. Obviously there must be a terrific number of people leaving the nursing profession after graduation.

Mrs. Spalding. I would like to refer questions relative to this to Miss Pfefferkon, who is director of studies of the National League of Nursing, who knows these figures backward and forward.

Miss Pfefferkon. We generally think there is an attrition of about 10 percent of the total graduate personnel yearly.

Mr. Biemiller. That means, then, that you are making no progress because you are graduating about 10 percent of that number a year.

Miss Pfefferkon. Well, we did last year, but we do not do nearly that well every year. In 1948 we graduated 34,000——

That is a very large class, because it had been admitted during the war, under the Cadet Corps program.

You see we had larger classes during the war than we ever had before.

Mr. Biemiller. As a result of the Government stimulated program?

Miss Pfefferkon. Exactly.

Mr. Biemiller. How many have you been graduating over the past 10 years?

Miss Pfefferkon. Generally, that was the largest.

Mr. Biemiller. I would like to have those figures submitted for the record. You may have had gradual increases over the last 10 or 15 years.

Miss Pfefferkon. Yes.

(The information requested is as follows:)

Table 3.—*Students admitted and graduated annually, 1940–48*

Year	Students admitted	Students graduated	Year	Students admitted	Students graduated
1948	43, 373	34, 268	1943	53, 074	26, 816
1947	38, 210	40, 744	1942	47, 500	25, 613
1946	30, 899	36, 195	1941	41, 397	24, 899
1945	56, 567	31, 721	1940	38, 113	23, 600
1944	67, 051	28, 276			

Source: NLNE, department of studies, 1948.

Mrs. Spalding. Mr. Chairman, with your permission, I would also like to ask if Miss Arnstein, who is with the Public Health Service, might present certain figures relative to what has happened during the past several years. Would that be permissible?

Mr. Priest. We will be very glad to have her do so.

Mr. Biemiller. May we assume or draw the conclusion, then, that you have been making some gain during the last 10 years in the number of nurses? You estimate each year there has been about a 10 percent——

Miss Pfefferkon. There has been about a 10 percent loss.

Mr. Biemiller. That is pretty high.

Miss Pfefferkon. Due to marriages, and other causes.

Mr. Biemiller. I recognize what you are up against.

Miss Pfefferkon. Yes.

Mr. Biemiller. Now, of course, that does take us back to page 3, where you raised the question as to whether or not there were enough nurses.

I believe in your testimony, Mrs. Spalding, on point 5:

Expansion of the Army and Navy Nurse Corps in connection with national defense—

You also added there in your oral testimony the Veterans' Administration as a further factor in drawing nurses out of the full population.

Mrs. SPALDING. Yes. Since we are now in a peacetime period we have an increase in patients in veterans' hospitals, whereas during the war period the patient average was on a higher level in Army and Navy hospitals.

Mr. BIEMILLER. Now, however, in drawing those nurses into either the Army or the Navy, in peacetime, it is done on a much larger peacetime basis than in the thirties, and then in addition to the Army and Navy they are being drawn into the Veterans' Administration, necessarily decreasing the supply of nurses available for the ill elsewhere, would not those nurses be treating these same people in civilian hospitals or private life, if it were not for the fact that a larger number than heretofore are now treated in the Army and Navy and Veterans' Administration hospitals?

Mrs. SPALDING. That is correct.

Mr. BIEMILLER. That is the point that I make. I do not think that there is a serious net loss, but they are drawn into these other groups.

Now, I think this is probably true, and this is the next point of the question. I believe that the Army and Navy, particularly, are maintaining a much higher percentage of nurses to their total enrollment than we normally would have in percentage of nurses to the total population. Is that correct or not?

Mrs. SPALDING. At this time?

Mr. BIEMILLER. Yes.

Mrs. SPALDING. And, of course, at this time, they are attempting to get more nurses, because of the situation that we happen to have at the present time.

Mr. BIEMILLER. And that is partly a matter of having to maintain probably a higher degree and percentage of medical facilities, let us say, overseas, for the same number of people than we would if they were in the United States.

Mrs. SPALDING. They are needed to care for the men who are overseas as well as those on duty in the United States, and, of course, we do at the present time have more in both the European area and the Japanese area.

Mr. BIEMILLER. Now, I do not want to prolong this, but I have one more question if I may, Mr. Chairman.

Do you have available figures from which you can answer this?

The Wisconsin officials of your association have talked with me and they maintain that one of the reasons why they have difficulty in getting a sufficient supply of nurses was the fact that nurses were excluded from the social-security program. They feel very strongly that nurses should be brought under the social security and that that would be one helpful additional reason that they could advance to persuade people to go into the nursing profession.

Has that been common experience?

Mrs. SPALDING. That is correct. I would like to ask Miss Beattie to comment on that. Miss Beattie is chairman of the American Nurses Association committee, on Federal legislation.

I would like to ask her to comment on that if that is satisfactory.

Mr. Priest. We will be very glad to have her do so.

Miss Beattie. Mr. Chairman, it is true that that is given as one of the reasons why there has been difficulty in recruiting nurses.

Our counselors in the high schools give it as one of the principal reasons for keeping young women from going into nursing. They do ask questions nowdays about the future of professions and these young women say they do not want to go into a profession in which they do not have the advantages of social security.

Mr. Biemiller. That is all. Thank you.

Mr. Priest. Mr. Wilson?

Mr. Wilson. Mr. Chairman, I think the committee ought to commend the witness not only on the splendid way in which she has documented her statement, but the manner of presentation and the convenience she has afforded the committee in the summaries that she has made.

I have a particular question that I would like to put to the witness. On page 10 of your statement, you say:

> Thirty-nine percent of the students in the class of 1947 and also in the class of 1948 withdrew before they completed their training.

That is nearly 4 out of each 10 young ladies who went into either a college or a hospital training school, somewhere in the course of the instruction saw fit to withdraw for some reason, economic or otherwise.

Will you elaborate, please, as to why they are withdrawing from those schools during their courses of instruction?

Mrs. Spalding. There have been several studies made in different States. Kansas is one of those States. I believe that Connecticut has also made a study. We also have in the 1948 "Facts about Nursing" of the American Nurses' Association, on page 39, a list of reasons why students withdraw from schools during their first 6 months. Would you like to have that?

Mr. Wilson. Yes; I would like to have any information along that line.

Mrs. Spalding. I will read it in the order that it is given: Failures in class work, 36.1 percent; dislike for nursing, 11.9 percent; matrimony, 10.7 percent; personal reasons, such as family complications, death in family, homesick, pregnancy, 9.8 percent; health, 8.4 percent; personality and temperament unsuited for nursing, 6.1 percent; immaturity, 3.5 percent; decision to go to college, 2.9 percent; disappointment in nursing course, 2.7 percent; failure to meet school's regulations and social standards, 2.6 percent; failure in clinical practices, 1.6 percent; financial reasons, 9 percent; other reasons, 2.8 percent.

I would also like to ask permisison to have Miss Pfefferkon comment on that.

Mr. Wilson. I would be glad to hear her, Mr. Chairman.

Mr. Priest. Yes, we will be glad to hear her.

Mr. Sadowski. What was that figure?

Mrs. Spalding. Failures in class work?

Mr. Sadowski. How many?

Mrs. Spalding. Thirty-six percent.

Mr. Sadowski. Thirty-six percent?

Mrs. Spalding. Yes.

Mr. PRIEST. Would you yield for one question before the young lady gives her testimony?

Mr. WILSON. Yes.

Mr. PRIEST. Do you have figures on the percentage of those who withdraw from the courses voluntarily and those who are requested to do so because of various failures of one kind or another?

Mrs. SPALDING. I would like to have Miss Pfefferkon comment on that.

Mr. PRIEST. Very well.

Miss PFEFFERKON. I would have to answer that indirectly, Mr. Chairman, but there are certain reasons within these reasons of withdrawals that indicate the student voluntarily withdrew and was not requested to do so by the school.

Examples of such reasons are disliked for nursing, matrimony, personal reasons, decision to go to college, disappointment in nursing course.

To come back to Mr. Wilson's question on that 39 percent withdrawals. The 1947 class was admitted in 1944. That was the largest class ever admitted in the history of nursing schools; 65,521 were admitted in 1944. Now, many of these students withdrew, as their husbands came back and the war was over. Many married as their fiancés returned from service and many who had entered schools of nursing for patriotic reasons withdrew. The loss to the hospitals or the universities operating the schools was tremendous. Multiply 65,000 by 39 percent and you get something like 25,000. Nearly all of the 25,000 withdrew during the first 6 months of training or first 8 months when the cost of their training is greatest.

The 39 percent that withdrew in 1948 were from the class who came in during 1945. Hostilities did not cease until August 1945, so that class, too, was part of the war recruitment.

During the war we let down on our selection techniques because of the urgency for numbers. Now we need to exercise greater selectivity in the admission of students. Just as long as we must recruit for numbers, we cannot use the selection methods that we would like to use and thus avoid these large withdrawals.

Mr. WILSON. Twenty-five thousand out of a class that entered in 1944 withdrew who would otherwise have graduated in 1947 and 1948.

Miss PFEFFERKON. That is right.

Mr. WILSON. That is nearly 10 percent of all of your present nursing staff of the country, country-wide, now?

Miss PFEFFERKON. It probably is.

Mr. WILSON. I notice in the break-down you gave of this 39 percent of the reasons that there was nine-tenths of 1 percent for financial reasons.

Miss PFEFFERKON. That is right.

Mr. WILSON. And less than 3 percent are for the purpose of going to college, evidently to pursue other courses?

Miss PFEFFERKON. That is right.

Mr. WILSON. I notice another figure on page 8 of the statement of 34,268 professional nurses were graduated and of that number 1,215 were graduated from collegiate schools and received their baccalaureate degrees.

That would be, if I figure right, about 3.6 percent or about 3½ percent of such graduates came out of colleges, or college supported schools, and received their baccalaureate degrees.

Then going further back in the statement I see that there were about 8 percent of all the colleges, of all of the schools that are college-supported schools and give degrees, and I interpret that to mean that 8 percent only graduated, 3.6 percent of all of the nurses that finished

Miss PFEFFERKON. That is true.

Mr. WILSON. Have you any further reasons to offer as to why; any reasons you know of other than the statistics you give, as to why the large number of withdrawals of girls who start in and never do finish?

Miss PFEFFERKON. I think probably part of that is revealed in the first listed cause for withdrawing, failure in class work. That is a very serious cause, because, again, it indicates poor selection.

The second cause is dislike for nursing, which is almost 12 percent. Of course, inherently, an individual may not like nursing, and she may find herself unsuited to it as she would to any other profession she entered. It is possible, however, that withdrawal because of dislike for nursing, which is 12 percent, approximately, and because of disappointment in the nursing courses, which is 3 percent approximately, might mean that there are conditions in schools which cause dislike for nursing and disappointment in the nursing courses, such as long hours, heavy schedules, and living conditions.

Mrs. SPALDING. I would like to add, if I may, Mr. Chairman, that one of the reasons why students withdraw is the lack of sufficient and qualified hospital nursing services administrators and teachers in our schools of nursing.

We have tried to point out several times how inadequate that situation is, and it is one of our No. 1 needs, if we are going to produce nurses of all kinds, to produce more qualified administrators and teachers for our schools of nursing.

I believe that people are almost as important if not more so than money.

Mr. SADOWSKI. I did not hear the last statement.

Mrs. SPALDING. I said, I am a great believer in the principle that people, and the environment in which we place people, are as important as money.

Mr. O'HARA. Even more so, would you say?

Mrs. SPALDING. I said "if not as important." Maybe it is more important. But also, we need the money to get these qualified people in order to have the type we need.

Mr. WILSON. You speak of the people who would instruct and administer, whether they would be in hospitals, whether they would be in colleges?

Mrs. SPALDING. That is correct.

Mr. WILSON. So much of the time now you have to depend upon part time and really a small part of the part time instructors.

Mrs. SPALDING. We have to depend upon unqualified instructors in addition to part-time instructors.

Mr. SADOWSKI. Mr. Chairman.

Mr. PRIEST. Mr. Sadowski.

Mr. SADOWSKI. What percentage leave because of economic reasons? That is, what percentage leave because they find better jobs in industry or in some other profession; better paying jobs?

Mrs. SPALDING. I am not sure that we have that information with us, but there have been studies made by the Department of Labor which we could submit.

Does any one present remember the figures?

Mr. PRIEST. If you can obtain those figures for the committee, we will appreciate it if you will do so.

(The information requested is contained in the Department of Labor Bulletin No. 931, which has been placed in the committee files.)

Mr. SADOWSKI. May I ask one more question, Mr. Chairman?

Mr. PRIEST. Yes.

Mr. SADOWSKI. Outside of the student aid that was given by the Government during the war, is there any other source for student aid that you know of? Is there any other fund available from private sources or are there any organizations; that is, social organizations, that aid these students?

Mrs. SPALDING. Yes.

Mr. SADOWSKI. Or loan them money; advance them money, to see them through school?

Mrs. SPALDING. There are some, and we do have a little publication which lists those that are available.

Mr. SADOWSKI. What percentage of the students have to be supported and aided and assisted by loans, from outside assistance?

Mrs. SPALDING. Do we have a figure that gives that?

Miss PFEFFERKON. No, we do not, but I think there is an answer to that, Mr. Sadowski, indirectly. Students have comparatively low expenses. In the hospital schools of nursing, they receive their maintenance. With respect to fees there are at present 30 schools in which the tuition fees and other expenses for the entire 3-year course are over $400.

A third factor which we have not discussed this morning is that students partly pay for their training in terms of service; service which they render to the hospital while they are learning nursing.

Mr. SADOWSKI. Even first-year students?

Miss PFEFFERKON. Yes; after the preliminary period; after the first 6 or 8 months. The amount of service students render varies from year to year. It reaches its greatest point in the third year.

The matter of financing of hospital schools of nursing is a very complicated one, because unlike most educational institutions, it receives its income not only from fees, taxes, endowments, gifts, but also from a fifth source: income from the services rendered to the hospital by students.

We have given some data in our testimony showing the difference between the annual income—and when I say income in schools of nursing, I mean the fees, plus services—and the annual expenditure per student to the operating institution.

In those sets of figures, the annual income is greater than the annual expenditure. That does not necessarily always happen. The better the school becomes the more of a financial liability it becomes to the institution. As cost analyses are made, we should be able to find out the difference between the annual cost to the hospital to train a student and the annual income to the hospital from students fee and services.

As we improve our schools, as we strengthen the programs, as the hours become shorter, as there are more graduate nurses and practical nurses carrying on the nursing services, the schools will necessarily cost the hospitals more and students will contribute less, and that, of course, is what we want to do. We want the students to have shorter hours; we want them to have a broader program; we want to make the schools of nursing like any other school.

Mr. Sadowski. I just want to ask one more question. What is the minimum requirement for entry into these hospitals, or the program as given to the hospitals or by the universities and various educational institutions that are giving these courses, and do they vary, and to what extent?

Miss Pfefferkon. So far as the State minimum requirements are concerned, it is high school. In the 48 States, there are some variations among the different schools.

About 97 percent of schools of nursing require high school graduation only. The other 3 percent require one or more years of college.

Mr. Sadowski. The minimum requirements are a high school diploma?

Miss Pfefferkon. That is correct. However, of all of the students who were admitted to schools of nursing last year, 89 percent were high school graduates and the remaining 11 percent had one or more years of college.

Mr. Sadowski. During the war those standards were lowered, were they not?

Miss Pfefferkon. No; I would not say that.

Mrs. Spalding. No.

Mr. Sadowski. They were not?

Mrs. Spalding. There has been no change in the admission standards.

Mr. Sadowski. Thank you.

Mr. O'Hara. Mr. Chairman.

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. I do not know to which of you ladies I should address these questions but I will inquire and leave the answer to your judgment.

Of course, the war conditions and the conditions which you have testified to in giving us the figures were unusual conditions. Is that true? You had nurses entering who were urged to enter. We had a great program to provide nurses. It did not necessarily make nurses as a final result. Is that not true?

Mrs. Spalding. I would not say that is true, Representative O'Hara.

Mr. O'Hara. Well, will you answer it in any way you want to? Answer it the way you think that it ought to be answered.

Mrs. Spalding. As a matter of fact, I think that what happened during the war period, in connection with the senior cadet period which provided that students could go into civilian hospitals or other agencies and into the Government agencies, during their last 6 months of training gave them an opportunity to have experience before graduation, which assisted them in doing a better nursing job more quickly, upon graduation.

Mr. O'Hara. Well, my point is——

Mrs. Spalding. Miss Pfefferkon just calls attention to the fact that we have some actual figures here in relation to the wartime program, if you would like to have those.

Mr. O'Hara. I understood those were the figures you gave. Were those the over-all figures for a number of years?

Mrs. Spalding. Those were over-all general figures. Which figures are you referring to now, Representative O'Hara?

Mr. O'Hara. Well, you were giving figures, one figure of 0.9 percent for failures.

Mrs. Spalding. That was the latest figure we have and it is in the 1948 edition, Facts About Nursing.

Mr. O'Hara. Well, were those figures which you gave—I have not found the place in your statement——

Mrs. Spalding. The figures we gave were from other sources.

Mr. O'Hara. Let me ask you for what period of time were those figures which you recently testified to, particularly in response to questions of Mr. Wilson?

Mrs. Spalding. Those figures were for the first 6 months of 1947.

Mr. O'Hara. Of course, that would include the result in part of the training program during the war?

Mrs. Spalding. Those figures would be just beyond that period.

Mr. O'Hara. Well, then, let us find out what happened during the war program.

Mrs. Spalding. Those are the figures which Miss Arnstein has. Miss Arnstein, will you give those?

Miss Arnstein. Mr. Chairman and Mr. O'Hara, we have just completed the total tabulation for Cadet Nurse Corps; 180,051 students were admitted under the Cadet Nurse Corps program and 124,065 were graduated. That is 30 percent, not a 39 percent withdrawal, for the total period of the Cadet Nurse Corps. I do not think you want the break-down.

We also have some figures on where they went to work afterward. They were sent follow-up questionnaires as to where they were working. We have that break-down, if you wish it introduced in the record.

Mr. O'Hara. That is quite all right. Why not introduce those in the record in a supplemental statement at this point, if you care to do so.

Mr. Priest. Without objection, we will be very happy to have those figures.

(The information requested is as follows:)

Employment Status Immediately After Graduation of Cadets Who Completed the Program of the USCNC

This information was obtained each quarter from each school of nursing. The school reported on the employment status of the students who had graduated that quarter, including those who had just graduated the day before or the week before the end of the report period. This fact accounts for the rather high percentage of persons who were awaiting assignment or whose employment status was unknown.

	Total	
	Number	Percent
Nurses who completed program	124, 065	100. 00
Distribution by employment status:		
Hospital where trained	57, 308	46. 19
Army Nurse Corps	3, 017	2. 43
Navy Nurse Corps	421	. 34
Veterans hospitals	3, 044	2. 45
PHS hospitals	222	. 18
Indian Service hospitals	179	. 14
Other hospitals	21, 265	17. 14
Public health nursing	2, 007	1. 62
Doctors' offices	2, 209	1. 78
Private duty nursing	4, 178	3. 37
Full-time advanced study	2, 045	1. 65
Other employment, not specified	372	. 30
Employed only intermittently	669	. 54
Not employed	8, 045	6. 48
Not known or awaiting assignment	19, 084	15. 38

Mr. O'Hara. Now, what I am getting at is—I am not trying to be subtle about it—in any program, whether it was the Nursing Cadet program during the war or whether it would be any program which would be initiated by the Government, you expressed it, I think, rather well when you said that it was personal; not only was it in your reflection on the candidate or the nursing candidate but in the first place she must want to be a nurse. Is that not true?

Miss Arnstein. That is correct.

Mr. O'Hara. And it is a hard training course to become a nurse and hard work after becoming a nurse—I mean it is hard in the sense that you have to work hard and you have a lot of responsibility.

Mrs. Spalding. It is difficult, but I do not think it is any more difficult than work in other professions, if you like it.

Mr. O'Hara. Well, that is the whole thing, "if you like it."

Mrs. Spalding. And I assume that that is true in connection with any profession.

Mr. O'Hara. Well, it is a highly honored and respected profession, of course; but I have seen, I have been in hospitals enough to see what these youngsters go through as novitiates starting their training.

Mrs. Spalding. In their first year, in their preliminary training.

Mr. O'Hara. They sort of get a "West Point" treatment, do they not, in the way they have to work pretty hard, and are subject to discipline.

Mrs. Spalding. I have never been to West Point.

Mr. O'Hara. Well, in the first place they are disciplined.

Mrs. Spalding. Of course, I do not know about West Point, but if I understand what you are implying, if it is in an educational institution that is operating under the objectives as it should——

Mr. O'Hara (interposing). Well, I am thinking first of the practical work; that is what I have in mind, when these youngsters start in the hospital to take their nurses' training, probably practical nurses' program.

Mrs. Spalding. The practical program.

Mr. O'Hara. Yes.

Mrs. Spalding. In the practical nurses' school.

Mr. O'Hara. Yes; when they go to the hospital to get their training.

Mrs. Spalding. In the hospital schools; you think that is difficult, that that is too difficult?

Mr. O'Hara. Well, I thought that they had to do a lot of scrubbing of floors and a little of everything. Is that not true?

Mrs. Spalding. Not as far as I know, except——

Mr. O'Hara. Maybe things have change since I was in a hospital.

Mrs. Spalding. The hospitals provide personnel for that purpose.

Mr. O'Hara. Well, is it just a lovely, nice, easy profession, then? Is that the point you wish to make?

Mrs. Spalding. No; I do not think anything worthwhile doing in life is easy.

Mr. O'Hara. Well, let me ask you this: You get your nurses, do you not, through two sources? One, through our college schools or university schools where they start in with the nurses' training program, which requires first academic work and then they go into the hospital. Is that not true?

Mrs. Spalding. In the collegiate and university programs they go into the professional or technical part of the program, in both publicly supported and in privately supported institutions. As a matter of fact, we have some figures on that.

Mr. O'HARA. I am talking about the practical side.

Mrs. SPALDING. Yes; we do have some figures on that.

Mr. O'HARA. All right; let us have them then.

Mrs. SPALDING. There are 95 basic collegiate schools of nursing. Of this number, 28 are publicly controlled and 67 privately controlled.

Mr. O'HARA. Well, what two ways does a girl who wants to be a nurse, or what ways—I do not care how many ways there are—in what way does she become a nurse?

Mrs. SPALDING. At the present time there are two types of programs: The hospital or, as it is referred to in the bill, the diploma program, and the collegiate or university program.

Mr. O'HARA. All right, now; let us take the hospital program. What does the nurse do who goes into that training program?

Mrs. SPALDING. When the nurse goes into the hospital program, as a rule they have what is called a preliminary period. During this period she learns the physical, biological, and social sciences, and some nursing. That is followed by actual experience in the different clinical fields, such as medical, surgical, obstetrical, pediatric, and other fields in the well-rounded programs. A well-rounded program, in addition to these four experiences that I have listed, would include psychiatric nursing, tuberculosis nursing, and nursing in the field of health.

Mr. O'HARA. And the technicians, that has nothing to do with the regular nursing program; is that true?

Mrs. SPALDING. That is correct.

Mr. O'HARA. Now, this young girl wants to become a nurse, and she goes into a hospital and she starts in, and she takes classes in the hospital and she is instructed in the hospital by instructors, both doctors and nurses, and she also does practical nursing?

Mrs. SPALDING. That is correct.

Mr. O'HARA. And for a certain period of time she is on probation, she is a probationary; is that not what she is called?

Mrs. SPALDING. That term has not been used for a good many years. She is on probation.

Mr. O'HARA. That shows how old-fashioned I am.

Mrs. SPALDING. She is on probation during the whole period.

Mr. O'HARA. All of that time?

Mrs. SPALDING. We would assume, however, that any student who should not be kept in nursing would be eliminated before she reached the end of her program.

Mr. O'HARA. How long does it take the average student in the hospital-training program to become a nurse?

Mrs. SPALDING. Three years.

Mr. O'HARA. Is she then a registered nurse?

Mrs. SPALDING. She is a registered nurse after she passes the State board examination in the State where she lives.

Mr. O'HARA. Then there is another type known as the practical nurses; is that true?

Mrs. SPALDING. There are practical nurses; yes.

Mr. O'HARA. And how does she become a practical nurse?

Mrs. SPALDING. I would like to refer that question, with your permission, to the president of the National Association for Practical Nurse Education, if that is satisfactory to you.

Mr. O'HARA. We will be happy to hear her.

Will you come up and give your name to the reporter, and we will find out something about practical nursing.

STATEMENT OF MISS ELLA THOMPSON, PRESIDENT OF THE NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION

Miss THOMPSON. My name is Ella Thompson, and I am president of the National Association for Practical Nurse Education, which is to practical nursing what the National League of Nursing Education is to professional nursing. I am a professional nurse, myself.

Mr. SADOWSKI. What is a professional nurse? Is she a nurse graduate?

Miss THOMPSON. Yes. Perhaps you prefer the term "registered nurse."

Practical nurses are prepared in approved schools, and their training is approximately a year, or it may be a little longer. There are in this country now approximately 76 approved practical-nursing schools. That means that they are approved by a State approving authority or approved by our association in a State where there is no approving authority for practical-nurse education as yet. There are schools like that in Minnesota, in Tennessee, in Wisconsin, and Michigan. They have some schools approved by our association, but not by a State-approving authority, because Michigan has no licensing law, and neither does Oklahoma at the present time.

Would you like to know the requirements for entrance into approved training? The minimum requirements set by the States are graduation from the eighth grade or completion of elementary school, or a State can set up an equivalency in that regard, also. Most of the schools are asking for the younger women now, below 25; 2 years of high school, at least; and some of the States ask for graduation from high school.

Mr. O'HARA. It is true, also, that many of the nurses who are practical nurses have the same initial education, the same as those who start in the other nursing courses?

Miss THOMPSON. Many of them do. They come from a different group in the high-school graduating class. They come from perhaps the lower two-thirds, rather than the upper third, in the graduating class.

Mr. O'HARA. How many practical nurses are there in the United States?

Miss THOMPSON. Well, I think that that is a $64 question. We have no way of knowing exactly how many, because the only source of information is the 1940 census, which listed 200,000 people practicing in this field. Now, of that, you have heard that 13,000 have graduated from approved schools, so you can draw your own conclusions about the caliber of nursing that is given by the rest of them. They are people who have gone into the field and are just working there without preparation.

Mr. O'HARA. How many did you say were graduates of approved schools?

Miss **Thompson**. Thirteen thousand and some odd.

Mr. **O'Hara**. Thank you, Miss Thompson.

Now, I have one other question, and we will go back to Mrs. Spalding.

Miss Thompson, Mr. Sadowski wanted to know whether a practical nurse gets a diploma.

Miss **Thompson**. Yes, sir; they are eligible in the States with license laws for the licensing examination, and become licensed practical nurses if they pass that examination.

Mr. **O'Hara**. How many years is that?

Miss **Thompson**. Approximately 1 year's training.

Mr. **O'Hara**. It is also true that in hospitals throughout the country and in the private homes throughout the country, that these practical nurses, so far as the limit of their ability, are doing the same work that the other nurses are, that is, within the limit that there is in practical nursing?

Miss **Thompson**. They are doing nursing, but taking care of the patient who is not acutely ill.

Mr. **O'Hara**. Thank you, Miss Thompson.

Now, to go to the other field, and that is the field that I wish to inquire about, the collegiate field of nursing, will you tell us a little bit about that, please, Mrs. Spalding?

Mrs. **Spalding**. There are less than 100 schools of that kind in the country; and, as has already been pointed out, graduates from high schools are admitted to those programs. These college and university programs are from 4 to 5 years at the present time, with the trend being toward a 4-year program, with certain parts of it in the college and certain parts in the hospitals or other agencies where nursing is practiced. That would include not only hospitals in the community, but such agencies as nursery schools, public-health agencies, and so on.

These programs should be set up by the college or the university so that they are an integral part of the college or university, with a college or university granting the degree.

As a result of such program, we would expect that those nurses would be able to nurse in hospitals, in the home, and in public-health agencies.

Mr. **O'Hara**. Do you know what the annual average graduation is from that type of nursing training?

Mrs. **Spalding**. As indicated in our statement, it is approximately 1,200.

Mr. **O'Hara**. Just 1,200 a year?

Mrs. **Spalding**. That is all, at this time.

Mr. **O'Hara**. Do you know what the annual graduation is in the University of Minnesota, for example?

Mrs. **Spalding**. The annual graduation of the University of Minnesota would be rather high.

Mr. **O'Hara**. They have a very extensive course there.

Mrs. **Spalding**. They have one of the very large schools. I think that they had 240 graduates from the University of Minnesota.

Mr. **O'Hara**. That is quite amazing; is it not?

That is all, Mr. Chairman.

Mr. **Sadowski**. Would you care, Mrs. Spalding—and I did not hear all of your statement—to tell us why there are so few graduating from colleges and universities?

Mrs. Spalding. One of the reasons there are so few, of course, is that the colleges and universities have not had the financial aid to create the kind of program that should be created. When a college or university operates a nursing program it must use facilities of other institutions, and it is very costly to secure these field agencies. That is one reason, and there may be many other reasons if anyone else here would like to list them, but I would see that as a major reason.

Mr. Sadowski. It just occurred to me that one of the reasons would be that the students could not afford to attend the college and university.

Mrs. Spalding. That is another good reason.

Mr. Sadowski. Is it another good reason, or is it one of the real reasons?

Mrs. Spalding. It is one of the real reasons.

Mr. Sadowski. You say there are about 300,000 nurses of all kinds, approximately 300,000 of all types at this time?

Mrs. Spalding. Three hundred thousand of those nurses who have graduated from the hospital schools and the colleges or university schools, and not including the practical nurses.

Mr. Sadowski. They are all gainfully employed, and there are jobs available for all of these nurses at the present time?

Mrs. Spalding. There are jobs available, and more.

Mr. Sadowski. Now, that is the question I wish to ask you. How many more nurses of that type—registered nurses and the graduate nurses, the college-graduate nurses—could be employed if we had them available?

Mrs. Spalding. The estimated need is 400,000.

Mr. Sadowski. You need approximately 100,000 more?

Mrs. Spalding. We need approximately 100,000 more.

Mr. O'Hara. How are we going to get them?

Mrs. Spalding. I do not know how we are going to get them. I would like to say that certainly, in summarizing some of the things we have said, in order to get them we need expansion and improvement of the facilities and instruction.

I would like to go back to that again, although it has been brought out. We need aid for those who cannot pay in the form of scholarships and loans until such time as the shortage could be relieved.

A third point that perhaps we ought to mention is that we need improvement of personnel policies and practices. This might be one way of increasing the number, through better employment practices. However, in making that statement, I would like to point out that the nursing profession and the hospital administrators have done a great deal in the past few years to bring about improvement as far as personnel policies and practices are concerned.

Mr. Sadowski. I have one more question, and it may have been brought out already before I came into the meeting. How many more practical nurses do we need? What is the need for practical nurses?

Miss Thompson. The need for practical nurses is great. It has been estimated that we ought to produce for the next 5 years 10,000 each year, and the need has not been determined any more nearly than that, because there are hundreds and hundreds of places where they could be used and where they are not now available to be used.

Mr. Sadowski. You mean 10,000 more than what you would normally produce?

Miss Thompson. Well, the normal rate of production is very low, of course, much below the need at the present time. It doesn't begin to produce the number of people needed, and that is one of the reasons why we are interested in Federal support for these programs in the States where the States are also interested.

I would like to introduce here something about Oklahoma. Oklahoma is interested in promoting practical nurse education, so it is not so backward, perhaps, in that field as it might seem.

If we had more programs we could produce more practical nurses. We could also put more people in the programs than they have now.

Michigan has conducted a very interesting experiment that is going on now.

Mr. Sadowski. I do not believe that I have the answer clear in my mind. This 10,000 figure that you mentioned, is that above the normal anticipated production?

Miss Thompson. Yes, sir.

Mr. Priest. Are there any other questions?

Mr. Wilson. I would like to ask one of the ladies about this terrible dreaded disease, polio. It is raging pretty strong in my home town right now, a town of 35,000, and there are 13 cases there at present. And I see by the newspapers, even today, that they are trying, by spraying of different chemicals, to do something about it. It is feared by the people greatly.

Do you have any figures of how many people are qualified to combat that from the nursing standpoint?

Miss Thompson. I don't know that we have the exact figures, but there is a very great need to prepare, first of all, instructors in the field.

Mr. Wilson. How long does it take to prepare a nurse to handle that? They have imported into my home town five or six nurses already, and they are bringing more in there, in the last few days.

Miss Thompson. It takes a very limited time. First of all, the nurse learns about that in her basic nursing; and now, to bring her up to date on some of the newer methods, all over the country they are having short workshops and short courses, and they extend anywhere from 3 days to a week, in order to bring them up to date.

Mr. Wilson. Can a practical nurse qualify for that and become versed and able to handle polio cases?

Miss Thompson. The practical nurse certainly can assist in the emergency situation, and assist in the nursing of such cases.

Mr. Wilson. Do you have any current release as to how many nurses throughout the country are qualified to handle those cases?

Mrs. Spalding. We have an organization that I believe could supply those figures.

Mr. Wilson. I want to talk just a little bit further about a matter in your statement because it strikes me as maybe a dilemma. In your statement you say the better the hospital school becomes, the better the facilities, the greater the liability the hospital school is liable to become itself. And as the program is expanded and the better trained they are and the wider service they render, the liability financially to the hospital becomes greater.

Mrs. Spalding. It is more expensive.

Mr. Wilson. It is in reverse proportion there. You drop down on your net income, because your wider extended services become a greater drain on it; and it seems to me like that is a dilemma. And that dilemma is one of the things that is calling for a change of something.

Mrs. Spalding. It is a dilemma.

Mr. O'Hara. Will my colleague yield with reference to the polio cases?

Do you ladies recognize the work which has been done by Sister Kenny?

Mrs. Spalding. Very definitely.

Mr. O'Hara. And, of course, she has done a lot of valuable work in this country up in Minneapolis and the University of Minnesota.

Mrs. Spalding. Yes. And I wanted to call attention to an organization that is one of these initialed organizations called JONAS, and the funds of this organization are supplied by the National Organization for Infantile Paralysis, and there are nurses representing the field of public health, hospital nursing service, nursing education, and so on, that are going over the country continuously, giving help to nurses especially in conducting some of these workshops that were mentioned a few minutes ago, and they also go into both the university and the hospital schools in making surveys in order to help them to reconstruct programs, especially in relation to polio and other related conditions and diseases.

Mr. Wilson. Will the proposed aid in title I of this bill to the nursing profession help remedy that dilemma that I just pointed out in your statement?

Mrs. Spalding. It should help.

Mr. Wilson. At present, the stronger we get and the better program we get, the greater the liability, financially, to the institution; is that right?

Miss Pfefferkon. Isn't it logical that in the conduct of a good educational program it should cost money? In universities and colleges, their tuition and fees are only about 58 percent of what it costs the university to educate its students each year.

Now, as students do less of those things, that Mr. O'Hara mentioned before, scrubbing floors, and if they still do in a few hospitals, and giving long hours of service, and reverse that situation to a good educational program, inevitably the schools will cost mney. The student will give less service. The hospital will have less income in the form of service rendered by the students. Consequently, it will cost the hospital more to operate a school. It is a perfectly logical educational principle.

No other school that I know of—there is no other school where the students pay not only the cost to the operating institution, but in some instances pay more than that cost.

Mr. Priest. Are there any further questions?

I believe all of the question that the chairman had in mind have been rather fully discussed.

Before coming to the next witness, the Chair has received a note from the audience, from a mother of a nurse, who desires to say a word about why so few graduate from colleges in nursing.

We are running about 30 minutes behind schedule; but, if Mrs. Butler can very briefly answer that question, we will be glad to have her do so at this time.

STATEMENT OF MRS. H. D. BUTLER, WASHINGTON, D. C.

Mrs. Butler. I am the mother of a girl who I urged to go into a university nursing school, and I want to support these ladies in their contention for getting higher-grade and better teachers. I think that that is one thing that fails to hold our girls, our college girls, in these schools.

My daughter was at Duke University in the war, and I persuaded her to leave Duke University at the end of the sophomore year and go into nursing, because it was a wonderful field for women. I think women need more and we need better nurses and more nurses. And she did this. But she found herself being trained by women who were just glorified nurses, and not good teachers.

Now, you take a college girl who is used to being under really trained teachers, and put her in a nursing school under girls who just have been nurses and not teachers, and you put her in an impossible environment.

I was so interested in the Congressman's questions about discipline. I think everybody needs discipline, and girls in nursing schools and everywhere else need discipline, but she found the discipline was overdone beyond all human necessity.

That again was a question of bad teaching. For instance, one of the girls in her class, a very pretty and a very capable girl who loved her nursing; the patients loved her, and she was a great success; at the end of her third year or the middle of her third year her father had cancer and was going to die within a month, and she went to the nursing superior and said, "May I have a month off to be with my father until he dies, and then you add a month to my training period?" And this nurse superior, who is notorious for her West Point methods, said, "You can take 2 days off, and if you aren't back you needn't come back at all."

Now, that was in the Columbia University School of Nursing. And I contend that that kind of discipline is not the kind that will attract your high-grade college girls or keep them; and the girls who left that school on the strength of that experience, the number of them was shocking. My daughter was among them. "We don't want to be in a profession," they said, "where the heart is ruled out of the profession that needs a lot of heart in it."

So, I want this committee to give money so these nursing schools can have higher-trained personnel, and then you will hold your college girls all right, because it is an exciting profesison for an intelligently trained girl.

Mr. Priest. Thank you very much, Mrs. Butler, and we are very happy to have your statement.

Mrs. Spalding. Might I make one statement in relation to this? We are very interested and concerned in having in nursing what I would like to call the triangle: that gets the right combination of the heart and the head and the hand. That is the skill that is needed for nursing.

Mr. Priest. All of your testimony indicates very strongly that you do have that as a motivating desire.

We thank you for your appearance before the committee.

The next witness will be Dr. Dressler. Is Dr. Dressler present?

STATEMENT OF DR. OTTERBEIN DRESSLER, DEAN OF THE PHILADELPHIA COLLEGE OF OSTEOPATHY, AND PAST PRESIDENT OF THE AMERICAN ASSOCIATION OF OSTEOPATHIC COLLEGES, PHILADELPHIA, PA.

Dr. Dressler. My name is Dr. Otterbein Dressler. I am dean and professor of pathology of the Philadelphia College of Osteopathy, and immediate past president of the American Association of Osteopathic Colleges.

Before entering my prepared statement, I want to say that I listened with interest to the testimony on the problems of the nursing profession, because we operate a school of nursing in our own hospital, and I am beset and besieged constantly by the problems of nursing education. I am delighted that it has received such a full hearing.

Mr. Chairman, we sincerely appreciate your invitation to express our views in connection with the medical-education-aid provisions of H. R. 3894 and title I of the twin bills, H. R. 4312 and H. R. 4313.

In order to simplify my statement, I shall confine my references specifically to title I of H. R. 4312.

The bill amends the Public Health Service Act to authorize three types of assistance: namely, aid for operation, construction, and scholarships.

As so amended, section 372 of the Public Health Service Act would authorize grants to medical schools for costs of instruction on substantially the following basis: for 3 years ending June 30, 1952, payments would be made at the annual rate of $300 per student for such number of students as the particular institution averaged in full-time attendance during the fall semesters of the preceding 3 years, and $1,700 for each student which shall be enrolled in excess of such average past enrollment. The amount of payments after 3 years would depend on legislation to be based on the results of a study provided for in the bill. Payments would be limited to 50 percent of the costs of undergraduate training, exclusive of operation of hospitals and research.

In addition to being public or nonprofit and Federal-income-tax-exempt, a school must be accredited by a body approved by the Surgeon General after consultation with a National Council on Education for Health Professions provided for in the bill. That might put the Surgeon General in the accrediting business, which has heretofore been in the last analysis left in the hands of the examining boards of the various States. We suggest that a public or nonprofit tax-exempt school whose graduates are eligible for licensure in a majority of the States ought to be eligible. Such a formula for accreditment is already a part of the Public Health Service Act. Section 5 (b) of the act of February 28, 1948, amending the Public Health Service Act, reads in part as follows:

> Graduates of colleges of osteopathy whose graduates are eligible for licensure to practice medicine or osteopathy in a majority of the States of the United States, or approved by a body or bodies acceptable to the Administrator, shall be eligible, subject to the other provisions of this Act, for appointment as commissioned medical officers in the Public Health Service.

Section 372 imposes a further condition of eligibility, and with your permission I will discuss that a little later.

Section 373 would authorize grants for construction and equipment for new schools and for improvement and expansion of present schools, including teaching hospitals and other related facilities and equipment thereof, but not to exceed 50 percent of the costs. In the case of hospital construction, the bill requires prior application and approval by the State and Federal agencies under the Hill-Burton Act. Such State and Federal approvals would not be subject to the priority restrictions of the Hill-Burton Act, nor would the grants be subtracted from the State allotment under that act.

Section 376 provides for scholarships to be assigned under State plans within quotas set by the Surgeon General, but affording not less than two scholarships to be assigned by each State in the field involved. The scholarships would include costs of tuition, fees, books and equipment, and subsistence, and would continue until the recipient finished the course offered by the school, provided he made continuously satisfactory progress.

Section 382 specifies that there shall be no Federal interference with the curriculum or administration of any school or the admission of applicants thereto, and also provides that neither the Surgean General nor any State agency may influence an applicant for or recipient of a scholarship in connection with his choice of a course of training or the institution where the course is to be pursued.

Section 217 would create a National Council on Education for Health Professions to consist of the Surgeon General, Commissioner of Education, the chief medical officer of the Veterans' Administration, and a representative designated by the Secretary of Defense, as ex officio members, and 20 members to be appointed by the Surgeon General with the approval of the Federal Security Administrator, 10 of the 20 to be selected from five specified fields, including medicine. It would be our suggestion that there should be a Council for each field, since the problems in medicine, dentistry, nursing, sanitary engineering, and public-health education are in many respects peculiar to each field. This is especially true in the case of colleges not associated with universities.

Now, I would like to revert to the provisions of section 372.

Possibly through inadvertence, the authors of the pending legislation failed to include colleges granting the degree of doctor of osteopathy as medical schools eligible for aid under the bill. Aid for costs of instruction and aid for scholarships are expressly restricted to "a school of medicine which provides training leading to a degree of doctor of medicine." The "aid for construction" section, being in the company of such restrictive applications of the term "school of medicine" would probably be construed as taking on the same exclusive character.

I say "possible inadvertence," because I cannot believe the authors of this legislation would deliberately confine participation to one school of training to the exclusion of another when both are engaged in comparable training of physicians. In legislating for the District of Columbia, Congress specifically declared:

> The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations.

This is in section 12, Public Law 831, Seventieth Congress.

We suggest that the bill be amended after the word "medicine," line 1, page 13, and line 13, page 23, by adding the words "or of doctor of osteopathy."

The declaration of policy on page 10 of the bill states "there is a shortage of physicians." On page 11 it declares that the costs of providing adequate professional training and facilities are so high and the sources of income of the schools affording such training are so limited as to render it impossible for schools training physicians to operate at present capacity on a financially sound basis. The policy statement concludes that it is indicated that the United States take steps to assist schools raining such physicians, in meeting the costs of instruction and giving financial assistance for construction and equipment of new schools and the expansion of existing schools and to provide scholarships to induce greater numbers of qualified students to enter in training for physicians.

There are six accredited colleges of osteopathy and surgery, all nonprofit and exempt from Federal income taxes, located as follows: Chicago College of Osteopathy, Chicago, Ill.; College of Osteopathic Physicians and Surgeons, Los Angeles, Calif.; Des Moines Still College of Ostopathy and Surgery, Des Moines, Iowa; Kansas City College of Osteopathy and Surgery, Kansas City, Mo.; Kirksville College of Osteopathy and Surgery, Kirksvile, Mo.; Philadelphia College of Osteopathy, Philadelphia, Pa.

Each of these schools trains physicians for the practice of the healing art in all its branches. In some 12 of the States their graduates are expressly licensed to practice medicine. It would be palpably unfair to extend Federal aid to one class of medical institutions training physicians for practice in those States while withholding it from another class whose trainees are granted the same licenses to practice. In more than a dozen other States, the graduates of these colleges are granted certificates as asteopathic physicians and surgeons and licensed to practice the healing art in all its branches, inluding obstetrics, drug therapy, and major surgery. In the remaining States the graduates are licensed to practice, in most of which their license includes obstetrics and minor or major surgery. All States license osteopathic physicians.

That these colleges provide training comparable to that furnished in schools granting the degree doctor of medicine is evidenced by the fact that a number of State medical examining boards have inspected the colleges and found them to be giving training of such comparable scope and quality, after which their graduates were admitted with graduate doctors of medicine to State medical examinations and awarded licenses to practice medicine and surgery. The Administrator of Veterans' Affairs, in carrying out his duties under the law establishing the Department of Medicine and Surgery, made a sufficient investigation to justify recognition of all these colleges of osteopathy and surgery as training institutions for physician appointees in the Medical Service of the Veterans' Administration.

As a result, licensed osteopathic physicians in all the States are granted authorization to render out-patient services for veterans with service-connected disabilities, and at least six osteopathic physicians have been appointed and are serving in the Medical Service of the

Veterans' Administration. The pertinent provision of the Veterans' Administration law (Public Law 293, 79th Cong.) reads as follows:

> SEC. 5. Any person to be eligible for appointment in the Department of Medicine and Surgery must * * * in the Medical Service, hold the degree of doctor of medicine or of doctor of osteopathy from a college or university approved by the Administrator, have completed an internship satisfactory to the Administrator, and be licensed to practice medicine, surgery, or osteopathy in one of the States or Territories of the United States or in the District of Columbia. * * *

In 1938, Congress expressly included doctors of osteopathy within the term "physician" for the purposes of rendering service for Government beneficiaries under the United States Employees' Compensation Act.

Soon after the outbreak of World War II, the Selective Service System requested the Office of Production Management to investigate the essential character of osteopathic practice, and the finding was that inasmuch as they are trained and licensed in obstetrics and surgery their practice should be accounted an essential activity. Later in the war, the Selective Service System expressly recognized the practice of osteopathic physicians as a critical occupation. A special bulletin was issued grouping together medicine, dentistry, osteopathy, and veterinary medicine, as critical occupations, the training for which was of such critical importance to the national interest that not only the students in these colleges were made deferable, but deferability was extended to include those taking preprofessional college work in preparation for entrance into the professional colleges.

It is my honor and privilege to be a member of the Healing Arts Educational Advisory Committee which was established in the fall of 1948 by the Director of Selective Service. That committee contains representatives of the American Medical Association, the Association of American Medical Colleges, the Association of American Dental Schools, the American Veterinary Medical Association, and the American Osteopathic Association. The committee unanimously advised the Director of Selective Service that the national interest will require graduates of medicine, dentistry, veterinary medicine, and osteopathy annually in numbers equal at least to the present level. To attest this, I will submit a copy of Local Board Memorandum No. 7 of the Selective Service System.

Mr. PRIEST. That will be filed for the information of the committee. Thank you.

Dr. DRESSLER. All osteopathic colleges require not less than 2 years preprofessional college education. The Bureau of Professional Education and Colleges of the American Osteopathic Association recommends that preosteopathic students complete 3 years of work. An average of over 60 percent of osteopathic matriculants in 1947 and 1948 had completed three or more years preprofessional college work and most of that number had obtained baccalaureate degrees.

The freshmen who entered osteopathic colleges in 1948 received their preprofessional training in colleges in 42 States, the District of Columbia, and 3 Canadian Provinces, and the 528 freshmen represented 236 liberal arts colleges and universities.

Rather than read these lengthy tabulations, if I may, Mr. Chairman, I will submit them to the reporter.

Mr. PRIEST. They will be filed for the information of the committee.

Dr. **Dressler**. The professional course in osteopathy and surgery extends over a minimum of 4 years. Graduates receive their intern training in 64 accredited intern-training hospitals.

The cost of training in osteopathic colleges for the fiscal year 1948 exceeded 3⅓ million dollars, less than 25 percent of which was paid for by tuition and fees. There are less seniors this year than any other years because that class entered during the time when preprofessional students were not deferred by Selective Service. For a number of years the average number of degrees granted exceeded 400. The current class is less than 150.

Like most of the medical schools, osteopathic colleges receive no assistance from public funds. Instead, they are dependent on the generosity of alumni and charitable institutions, and these sources are becoming less and less sufficient. Deficit financing is a necessity. More and more time and effort by college administrative personnel that should be devoted to operational purposes must be spent in fund raising.

In the meantime, costs have multiplied. Faculty members are serving at a sacrifice. Indeed, unless some such assistance as that proposed in this bill is made available, our faculties will be depleted. We are in desperate need of expanding our out-patient teaching departments, our laboratories and classrooms. Our equipment needs replacement. Much of it is obsolete.

Adequate training of physicians to care for the health of the people is a tremendous responsibility. The needs are great.

In concluding my statement, may I refer to another pending bill, H. R. 3828, entitled "Federal Aid to Medical Education Act of 1949," introduced by Mr. Wheeler, of Georgia, which defines the term "approved colleges and schools" to mean "colleges and schools of medicine, surgery, osteopathy, and dentistry which are approved by the Board."

I should like also, rather than occupy the time of the committee, to submit for the record certain excerpts from the guidance leaflets of the United States Office of Education.

Mr. **Priest**. They may be accepted for the information of the committee.

Are there any questions?

Mr. **Sadowski**. How many more students could you accommodate in these colleges than you now have? You say that these colleges are not filled up to capacity; is that correct?

Dr. **Dressler**. Well, the upper classes are small at the present time because of the restrictions during the war period. One of our greater concerns is, Are we going to be able to survive with the numbers we have even now, or will we have to cut back to a smaller number?

Mr. **Sadowski**. What about the applications that are coming in now to these schools that you mentioned in your statement? You mentioned six accredited schools. Do they have sufficient applications to fill them up entirely?

Dr. **Dressler**. We have applications, and in fact the Office of Education has recently reported that of all the applications for schools of medicine throughout the United States, about 1 out of 5 applicants is accepted; and about the same ratio applies to our own schools. In my own school, we had applications, bone fide applications, of approximately 500 this year, and we will accept 90 out of the 500.

Mr. Sadowski. And then the class will be filled?

Dr. Dressler. Oh, yes.

Mr. Sadowski. So if you had more facilities available, you could accommodate more students?

Dr. Dressler. We should like to.

Mr. Sadowski. Well, now, you not only would like to, but you could; is that correct?

Dr. Dressler. Yes, sir. I think that we could perhaps accommodate another 10 percent. But our major problem is, Can we survive carrying even those, with the present deficit accounting that is necessary because of lack of funds?

Mr. Sadowski. Anyhow, I gather from your answer that you could not take on any more students into these colleges than you have taken on, and there are no vacancies available?

Dr. Dressler. There are no vacancies available, sir.

Mr. Sadowski. That is what I wanted to find out.

Dr. Dressler. The condition is quite the reverse. It is a condition of desperate overcrowding.

Mr. Sadowski. That is all.

Mr. Wilson. Only 12 of our 48 States give a license to your members?

Dr. Dressler. All of the States grant licenses, but in some States it is before the usual board and in some it is an independent board or a composite board. I have submitted to the reporter a composite of the various laws of the various States in that regard.

Mr. Wilson. The proposed legislation, under title I, does not appear to cover chiropractics, but you understand it to cover your own profession, osteopathy?

Dr. Dressler. It is specifically excluded in this particular title, and that is my purpose in being here, because it is specifically excluded; whereas, in the previous acts codifying the Public Health Service, it was specifically included. And that is my purpose in being here, so that we might be included in title I of this bill. According to your section 372, we are definitely excluded.

Mr. Sadowski. My own personal feeling is that you should be included.

Dr. Dressler. We feel it was an oversight in the drafting of the act, since the Congress has repeatedly dealth with the degrees "doctor of medicine" and "doctor of osteopathy" on the same basis.

Mr. Wilson. You say section 372 expressly excludes you?

Dr. Dressler. Yes; on page 12 of the bill; page 12, line 25, including line 1 on page 13: "to each school of medicine which provides training leading to a degree 'doctor of medicine' "; whereas, in other acts, it reads, "doctor of medicine or doctor of osteopathy."

Mr. Wilson. I have been laboring under the impression that that was a question for interpretation there, and possibly it was included. But maybe I am wrong in my opinion.

Dr. Dressler. Well, we have entertained that thought also, except this one technical matter that our schools do not issue a degree "doctor of medicine." They issue a degree "doctor of osteopathy." Other acts of the United States Public Health Service recognize both degrees. This act should conform with the previous acts.

Mr. Sadowski. Doctor, one more question. Are there any schools in osteopathy which will give a degree on a basis of lesser requirements than 2 years of precollege and 4 years of osteopathy?

Dr. Dressler. No, sir; there are none.

Mr. Sadowski. There are none in the country today?

Dr. Dressler. There are none.

Mr. Sadowski. There used to be?

Dr. Dressler. Yes, sir.

Mr. Sadowski. That has all been corrected?

Dr. Dressler. That is true.

Mr. Sadowski. In view of that, I cannot see why your schools should not be included and given the same consideration as schools of medicine, because you have met the requirements.

Dr. Dressler. That is right.

Mr. Priest. Are there any further questions?

Mr. O'Hara. Do most of the States have what we call a basic science law?

Dr. Dressler. I have forgotten. Perhaps counsel can tell me how many States have basic science laws. There are some new ones within the last legislatures. As an example, Texas has established a basic science law this year.

Mr. O'Hara. As you know, we have had one in Minnesota for many years.

Dr. Dressler. I am not up to date on the exact number at the moment, but I do recall that recent sessions of the legislature in Texas enacted a basic science law.

Mr. O'Hara. What do you think of the Minnesota law?

Dr. Dressler. It is splendid.

I am told that 22 States, including Alaska and the District of Columbia, have basic science boards, two of which, Kansas and Virginia, are not applicable to doctors of medicine or doctors of osteopathy.

Mr. Priest. We appreciate your testimony. I assure you that your views will be given full attention of the committee.

STATEMENT OF LAWRENCE L. GOURLEY, LEGAL COUNSEL, AMERICAN OSTEOPATHIC ASSOCIATION

Mr. Gourley. I am Lawrence Gourley, legal counsel for the association, and I would like to clarify the answer to Mr. Wilson's question about 12 States licensing them to practice medicine.

All States license osteopathic graduates.

That reference has to do with 12 States granting to osteopathic graduates specific licenses to practice medicine and surgery. I mean, in 12 of the States they have the same license as doctors of medicine. In another 15 States, it is osteopathy and surgery, with unlimited privileges.

Thirty-five States license osteopathic graduates to practice obstetrics and major operative surgery. Other States impose limitation in varying degree.

Mr. Priest. The next witness is Dr. Cornell Grossman. Will you come forward, please?

STATEMENT OF DR. CORNELL GROSSMAN, DENTIST, MILLBURN, N. J.

Mr. Priest. Before you proceed, may the Chair ask a question here in order to determine our future course for the day?

We have Dr. Francis J. Brown and Brig. Gen. James Steven Simmons as two other witnesses that we wish to hear today. Following Dr. Grossman, if it is agreeable to the committee, we might adjourn for lunch and come back at 2 o'clock, if that is agreeable to the witnesses. However, I would not want to do so unless that is agreeable with everyone.

Proceed, sir, please.

Dr. Grossman. The bill perpetuates an antique system of dental and medical education, and at this time it would be appropriate to obtain more dentists and more doctors more quickly and yet maintain the same high standard and save the Government money and the public and the students a great amount of money.

The first way to do that is, that at the completion of the 4-year high school course shall be the sole requirement for admission to any dental or medical college. The high school course may be commercial, vocational, or academic, and shall not of necessity require Latin, algebra, geometry, trigonometry, and kindred subjects that have no bearing on an art that depends upon the skill of the hands. There is no mathematics in dentistry, and no mathematics in medicine. It is all done by the eye and, where an X-ray machine is used, it is done with automatic charts.

Now, the dental-college course shall be 4 years and in the first 2 years shall be included sufficient mechanical dentistry to grant to the dental student a certificate at the end of 2 years that he is a dental-laboratory technician. Three hundred and twenty-five students entered my class and at the end of the first year 175 flunked out. Had they been given a little more mechanical training they could have been mechanical dentists and stayed in the profession or ultimately become dentists, instead of drifting away with very little training.

The medical course shall be 6 years, and so arranged that the medical student at the end of 1 year shall receive a certificate that he is a medical-laboratory technician. The big drop in the medical school is in the first year, one-half are usually flunked out, and if the boy has gone to college for a year he could still be in some part of the medical profession as a technician. The course need not be changed greatly for that. At the end of 2 years, he shall receive a certificate that he is a medical nurse. At the end of 3 years, he shall receive a certificate that he is an X-ray technician. A great number come near the end of the course, and then their health snaps or they just cannot stand it any more, but had they had training and given a certificate that they are X-ray technicians they could step out of medical school and get a job in a hospital or in the X-ray field, and have something.

At present, when the student quits medical school, he is a licked person, and 90 percent quit the school before they ever get a degree. At the end of 4 years he shall receive a certificate that he is a graduate pharmacist, and that is equivalent to saying that he can have a drug store or be a pharmacist, and I want to point out that all of these subjects are part of the medical course, and that by granting the certificates, and granting them at the end of each year, you will have better medical students, because of the fact that if the boy is going to get a certificate at the end of the year that he is an X-ray technician he is working for something in the immediate future. If he is going to get a certificate showing that he is a pharmacist at the end of 4 years, he can see something quicker and the medical course today is about 10 years long and most of them do not survive.

At the end of 6 years he shall receive his degree as doctor of medicine and surgery, and be eligible for his license examination.

Now, I would urge that the internship year be included in the 6-year medical course, and you will have a better doctor in that way because if he is interning in a poor hospital or in a place where he receives no training in internship, and if he is still connected with the school, there is a control there.

I would urge, too, that the minimum salary be established for the intern. This is aside from this bill, but I urge that a minimum of about $125 a month, and maintenance, be allotted because after a boy has gone to school he is 24 years old, at least, and should not be made to work for next to nothing.

Under this program the average medical doctor would be at least 24 years old at graduation, and the big point is that he would have been studying medicine itself and in practice in medical infirmities from the age of 18 to 24 years.

His basic science subjects of chemistry, physics, atomic chemistry, and everything else are included in his 6-year course. This is no innovation, it is the course that I took. The old doctors of today in medicine had 4 years of high school, 4 years of medical college, and when they came out they were better doctors than they are today and more skilled at delivering babies, and the reason is that they went into medicine at the age of 18 and went into the clinics. As 18 they could go up to the big ampitheater and watch the chief surgeon work, and that is the privilege of the freshman or anyone. They could go into the maternity ward and assist, and they were delivering babies and working from the age of 18 to 22. When they are working at that age at medicine they are learning medicine, but under today's program they go to college from the age of 18 to 22 and they do not know anything about medicine, and by the time they get to the medical school the skill in their fingers is nil and you cannot teach an old man how to use his fingers. Manual training of the fingers can be acquired only through youth. That is the intricate skill that is involved.

We are not making a poorer doctor, we are giving him more medicine, and we are giving you a broad plan with a full knowledge of people and understanding, because he is developing more character in the medical school and he is meeting the patients and learning how to handle them and working under good doctors. He is away from the academic things, and in the realities of the case.

The present medical program is an antiquity. The universities of our country acquired the medical schools and, after acquiring the medical schools, they insisted on academic training at the university. Now, what was the net result in my own school? I went to the New York College of Dentistry in 1921, but by a technicality I received my 4-year high-school diploma and had to take an extra year of high school to get my biology. The biology did me no good, because I was a farm boy and I knew more than the teacher about animals and bugs and plant growth. I brought bees to school and put them in the classroom for them in order to show them how to handle bees. Now, the thing is that I had had everything already that biology tried to give me. I had taken physical geography and physics and I had physiology in the eighth grade and yet I had to spend an extra year in this high school.

I would have been a better dentist at the time if I had spent an extra year after I graduated in practice. Just because a boy goes into school and becomes nimble with his fingers by typing and becomes orderly with his mind in bookkeeping is no reason for keeping him out of a dental school and saying that he has to go back to high school to get a high-school subject. Every subject taught in high school, scientific subjects like chemistry and physics, is taught again in the dental college. That is, they feel that your chemistry at high school was no good because they knew nothing of dental materials or their intricacies and the specialties, so you had to take 2 years of even chemistry in the dental college, as you should. But had you never had high-school chemistry, you could be just as good a chemist or dentist.

The point that I wish to stress is that the dentist who graduated in 1921 is more skillful than the graduate of today, after 8 years of schooling. My course was 4 years, direct from high school to dental school. I was young, as were the other fellows, and we went right to work fixing teeth, from the age of 18 to 22, when we graduated. We knew how to hammer faster and work better than the boys of today, mechanically speaking, because the boys of today have wasted away 4 years of their life in college and they are ready to throw it up, and they know that if they have to go to school and study any more they are finished. They try to master dentistry from the ages of 22 to 26, and you might as well say you cannot begin to study to be a carpenter or plumber until you hit the age of 22, because the skill in your fingers is what counts, and that they acquire when they are younger.

In other words, the dentists today graduating under this program would be 22 years old.

Now, in the matter of profits in dental schools and their need for help: The New York College of Dentistry earned $750,000 profit over and above all operating expenses for a 15-year period, that is an earning of $1,000 a week. New York University acquired the school because it earned money in the clinics, and the university took the $750,000 from the dental school. As a result, the dental school today can take in only 150 students, whereas in my time it took in 325, and it is the largest dental school in the world. In other words, the profits that the dental schools earn in their clinics because of students working for nothing and the patients being charged pretty good fees, are taken from the dental college and put into other schools of the university.

If you grant money to these schools you certainly will have to protect this money, and see that it stays in the dental schools, and the money they earn should stay there, too. It wouldn't do to have the $750,000 that they earn along with money you give them. That was given to me by the dean of the college, the man who was dean for 15 years, Dean Newman. He is the past president of the American Association of Dental Colleges. He states that it is they who limit the colleges and the number of students, and it is the Carnegie Foundation, so if the school had been allowed to keep its profits it would have that much added facilities for larger classes, and you would not have had the shortage of dentists.

This program will give you more dentists quicker, and you get one in 4 years instead of 8 years, and you get a doctor in 6 years instead of about 10, and you get a better dentist and a better doctor, a younger man who has developed more skill in his fingers because he began younger, when he was still interested. Going to predental college kills your interest in the real professional work, whereas going from high school straight into dental college stimulates interest in the work.

I would like to point out that if you are going to increase the numbers of dentists and doctors, you are going to have to increase the demand. People have to have the money to pay for it. The reason people cannot pay for needed services in dentistry, medicine, and other things is because they have to pay income taxes. If they didn't have to pay income taxes they would have enough money in most instances to get these needed services. The income tax, snapped right out of the wage earners' pay before the even sees the money, means that he cannot pay his full amount. By the end of 5 days after pay day he is broke. Since our unemployment is so greatly on the increase, the abolition of income taxes would mean greater purchasing power in this field and every other field, and the men that you are going to train would have a population that could buy the materials.

I would advocate the abolition of corporation taxes and profit taxes, so that they could hire more, and people could have the money and they would then have more jobs and money to go to the dentists or do the things that they need to do.

Now, if you want to get a control of polio and prevent it, I might tell you that it begins in dentistry. The average person has five cavities, and if you take the virus of polio and bury it in a dead tooth or a decayed tooth, the patient will have polio because it is in that decay that it has to grow and thrive. If you have a population which has so many decayed teeth, you need more dentists. Four years is all they spend in a dental school, and they get their science with it, and they get their clinical training with it. A young man graduating at 22 is a better dentist than one who is all petered out at 26 and only began his practical work at 22.

Mr. PRIEST. Doctor, we thank you for your statement, and we are glad to have you before the committee.

Dr. GROSSMAN. Thank you. I hope a boy can go from high school to medical school, and not have to go to an academic college first for 4 years only to find that there is only room for 1 in 30 applicants at the medical college.

Mr. PRIEST. Mr. Brown, we would like to hear from you now, if you please.

STATEMENT OF FRANCIS J. BROWN, STAFF ASSOCIATE OF THE AMERICAN COUNCIL ON EDUCATION, WASHINGTON, D. C.

Mr. BROWN. I appreciate this opportunity, Mr. Chairman, and members of the committee.

My name is Francis J. Brown. I am staff associate of the American Council on Education and secretary of the committee on relationships of higher education of the Federal Government of the council, and committee that was organized in 1940 and has been in continuous function ever since.

The council consists of 68 constituent members, 57 associate members, and 929 institutional members composed of higher educational institutions and school systems, both public and private. In other words, the council is a holding company in the field of education, with primary interest in higher education.

The members of the committee on relationships are as follows: Arthur S. Adams, president, University of New Hampshire, Durham, N. H.; Leonard Carmichael, president, Tufts College, Medford, Mass.; Carter Davidson, president, Union College Schenectady, N. Y.; Virgin M. Hancher, president, State University of Iowa, Iowa City, Iowa; Rev. Edward V. Stanford, rector, Augustinian College, Washington, D. C.; Raymond Walters, president, University of Cincinnati, Cincinnati, Ohio; Chairman Roscoe L. West, president, State Teachers College, Trenton, N. J.; Goodrich C. White, president, Emory University, Georgia; George F. Zook, ex officio, president, American Council on Education; Francis J. Brown, staff associate, American Council on Education, secretary.

At the meeting of the committee on May 16, it unanimously endorsed in principle those sections of H. R. 4313, which provide Federal assistance to both privately and publicly controlled institutions providing professional training in the fields of medicine, dentistry, nursing, public health, and sanitary engineering. The committee believed that all three types of aid included in the bill H. R. 4313 are important: for cost of operation, for construction and other costs to provide physical facilities and for scholarship aid to students. But the committee was strongly of the opinion that the most imperative present need is assistance in bearing the operational costs of the institution providing training in these fields.

I need not take your time to emphasize the importance of these fields in the national interest. Their importance is greater today than ever before because of the increased birth rate; it is estimated that there are now some 8,000,000 more children under 9 years of ago than there would have been if the birth rate of the 1930's had continued. It is important also because of the rapid advances in all of these fields which entail a higher level of training and increased specialization. But what I want especially to emphasize is that the vital importance of all of these fields make financial assistance to them by the Federal Government seem to be essential to the advance of the public welfare.

But it may be asked: "Why should the Federal Government begin now to expand the public welfare clause to provide financial assistance to this special group of professional institutions?"

At least three answers to this question occur to me: One is that the need for manpower in these fields is very great today. I have already referred to the increase in population but there are other factors which bear upon this question. Our armed forces must secure the services of many additional physicians and dentists. These professional men are absolutely essential to the welfare of our armed forces in this period of great international uncertainty. The civilian population has now only one doctor for each 700 persons, a large proportion of whom are children and elderly persons for whom medical and other health care is imperative. If the needs of the nationl defense are to be met, the training facilities for these fields must be expanded beyond the prewar level. Such expansion is costly both in initial outlay and in operating costs. The ratio of doctors and other persons in these professional fields to the population is not on the increase, but it is actually on the decline. Consequently, the demand is great for increasing the facilities of training persons in these fields.

The second reason why financial assistance is needed now is the rapid increase in the cost of operating institutions to train professional men and women. In the last 10 years the equipment required to train students in these fields has vastly increased in cost. Many instruments of an old-fashioned, simple type are now supplanted by electronic and other devices which often cost not 10 but thousands of dollars. Today it involves machines such as the electrocardiograph costing more than $1,000. Even the simple laboratory equipment now costs two or three times what it did in 1940. But physical equipment is not the only increase in the cost of operation.

Faculty salaries in these fields have also had to be increased. Especially in clinical teaching the salaries paid to full-time professors are now up to twice as high as the compensation paid regular faculty members; but that is the lesser aspect of the cost. The reason is that those in practice can gain incomes in excess of that which the institutions can afford to pay them.

Specialization and research tend constantly to reduce the faculty student ratio and make it necessary also to increase the faculty even with the same number of students. The actual cost for operational expenses in medical schools average approximately $2,500 per student per year. The result of these increasing costs now make the professional school in these health fields draw heavily upon the total university budget frequently at the expense of other schools of the university. I would not refute the statement just made to this committee in regard to the New York school, but I can say that in many instances the exact reverse is true. Two college presidents have told me during the last week that the deans of the medical and dental schools tell them what they have to have to operate their institutions, while the president tells the deans of the other colleges what they can spend, and the drain is very heavy as a result of the large costs going into medical and dental education, especially as well as into these other professional fields.

The third reason is that other sources of income to these fields are decreasing. I am informed that 85 percent of all money raised by income taxes of all kinds—local, State, and national—are now levied by the Federal Government. This means two things: First, that revenues from local and State taxes are not sufficient to meet the expanded needs and, second, that less money is now available which might otherwise be given to educational institutions from private sources. The rate of income on endowment funds has decreased in recent years. Student fees have been raised, but there is a limit above which they cannot go.

Even now medical and dental education is restricted to individuals who can finance training which costs, including room and board, up to $3,000 a year.

Institutions of higher education and especially those operating professional schools face a dilemma. It is frequently restricted to only sons and daughters of well-to-do families, those who can afford to pay up to $3,000 per year for the training. The need for trained personnel in the health field is rapidly increasing. The cost per student is now almost twice what it was in 1940. Every possible present source of income is either constant or actually declining and the only resource is to turn to the Federal Government.

Any one of the 78 universities having medical schools could be used to illustrate the generalizations I have made thus far. Tufts College, Medford, Mass., is typical of the dire problems which now face all institutions in maintaining adequate training for the health fields—problems that are even more serious in the light of needed expansion to meet increasing needs.

Except for a few thousand dollars in Vermont, no State appropriations are made for medical or dental education in New England. The nonpublicly supported schools in that area must therefore carry the burden of providing physicians and dentists and other medical personnel for this whole group of States. The total budget of Tufts College Medical School in 1937–38 was approximately $272,000. Last year the cost was over $646,000. The number of students remains constant during this period, and the change of income from tuition provided an increase of only about $48,000. The Tufts College Dental School shows a similar change.

They are operating under a large deficit and this cannot continue indefinitely. New England people and especially their alumni have made generous contributions to their schools of medicine and dentistry, but private benefactions do not seem able to carry the burden. I have used medical schools simply as illustrative material, but the same thing can be said for these other professional fields that the committee is considering.

In the light of these facts the committee on relationships and I personally strongly urge this committee to approve financial aid to the institutions training young people for the health fields specified in this bill, including schools of osteopathy not now included. Financial assistance for both operation and construction is imperative. Some scholarship program for students may be advisable, but the real need is that of the institution.

The comimttee did discuss the proposal for scholarship aid and it feels that that would be desirable, but it feels it is true that the most imperative aid would be aid to the institutions.

Mr. Priest. We thank you very much, Mr. Brown.

Are there any questions?

We are very happy to have a ranking member of the full committee present at this time, Mr. Wolverton. Do you have any questions?

Mr. Wolverton. I have no questions.

Mr. Priest. We thank you very much, Mr. Brown.

Our concluding witness will be Brig. Gen. James Simmons, who is dean of the school of public health at Harvard University.

We are very happy to have you, General.

STATEMENT OF BRIG. GEN. JAMES S. SIMMONS, UNITED STATES ARMY, RETIRED, PRESIDENT OF THE ASSOCIATION OF SCHOOLS OF PUBLIC HEALTH, HARVARD SCHOOL OF PUBLIC HEALTH, CONNECTICUT

General Simmons. I want to thank you and the members of the committee, sir.

The Association of the Schools of Public Health, of which I am president, is grateful for this opportunity to testify on title I of House of Representatives bills 4312 and 4313, and also H. R. 3894.

The association represents all the schools and departments of public health in universities of the United States accredited to give postgraduate training in this important field. These institutions serve the Nation as special educational centers for health personnel. They maintain the advanced training facilities required to produce health experts and leaders for planning, organizing, directing and operating such programs of public health as may be adopted by our Nation.

Thus we have a keen interest in the various health plans your committee is now considering. Regardless of what plan may be adopted, we wish to emphasize the necessity of making adequate provision for training all the professional manpower required to operate an effective total health program.

It is the purpose of my testimony to indicate the contribution which our schools are qualified to make to such a program, and to recommend the necessary financial support.

We all agree that public health is concerned with the prevention of disease and the development of optimum physical and mental health. Primarily, it includes those preventive activities which are recognized as a community responsiblity, from sanitation, nutrition and hospital administration to the control of diphtheria and cancer. Public health today is our greatest hope for the future eliminiation of virtually every disease, including many of the afflictions of old age.

To sum it up, public health is the science of keeping people well.

With this in mind, let me tell you something about the schools I represent:

The nine schools of public health, or departments, in the continental United States are located at the Universities of California, Columbia, Harvard, Johns Hopkins, Michigan, Minnesota, North Carolina, Tulane, and Yale. They are accredited by the American Public Health Association to give training leading to the degrees of master or doctor of public health, or master of science.

Established within the last three decades, these schools are dedicated to a new concept of service through adding to the Nation's facilities for medical training an entirely new type of institution devoted to postgraduate training in public health. They were conceived and designed to supplement the humane services of curative medicine and to provide effective postgraduate instruction in the modern techniques of wholesale community disease prevention and health conservation.

Their objective is to control disease on a broad scale and to bring better physical, mental, and social health not just to the individual, but to large masses of people.

The schools approach this objective through integrated programs of postgraduate instruction, research, and community service. These programs are designed to produce the expert specialists required for community and national health; for the health of industry, both labor and management; and for international health agencies. They train administrators for general health programs, and specialists for programs in industrial health, maternal and child health, mental hygiene, and for the control of cancer, venereal disease, tuberculosis, and tropical diseases. Other important functions include the training of administrators of hospitals, clinics, and service programs, and teachers for schools of public health and departments of preventive medicine in medical schools.

The training programs provided by the different schools vary. However, they all emphasize the postgraduate training of students who are already qualified in various branches of science important to public health, particularly physicians, dentists, or veterinarians. After one or more years of intensive training, these graduates go into the essential health positions already indicated. Many of them accept Government positions. Therefore, the schools of public health render a direct government service comparable to West Point and Annapolis.

If the Nation's health program is to be expanded, we must have more experts of the types now being trained by these schools.

During the academic year 1947–48, 655 students were enrolled in accredited schools. Of this number, 482 were candidates for special degrees or certificates, which indicates a considerable increase over the annual output of the past 10 years. This is not sufficient even for present national needs, much less for the requirements of any expanded program.

Recent estimates made for the association by representatives of the United States Public Health Service and various professional groups indicate that about 35,800 individuals are now engaged in full-time public-health work in the United States. Eighty percent of these are serving in official and 20 percent in voluntary health agencies. Only about one-third have had formal training in public health.

It is estimated that an adequate national program will require about 68,000 health specialists in 1960. These estimates were made by the expects of the Public Health Service with the assistance of the deans of the school and the American Public Health Association. This includes physicians, nurses, engineers, sanitarians, dentists, health educators, and laboratory workers. We must also provide medical-care directors, nutritionists, statisticians, and other public-health workers.

Thirty percent (or 20,000) of this 68,000 will require advanced training of the type now available in the accredited schools. To fill these 20,000 positions by 1960 and allowing for retirements and turnover, the annual postgraduate-training need will be at least 2,300 per year.

This is more than three times the total number of students who attended schools of public health in 1947–48, and about five times the number who received certificates and degrees that year. On this basis the country's facilities for postgraduate health training must be increased for two reasons: (1) to train new health personnel and (2) to train a portion of the personnel now employed in this field.

Such increased training can be provided either by expansion of the present schools or by such expansion supplemented by the establishment of new schools. In either case it will be necessary to determine the total cost of such expansion and to make adequate provisions for financial support.

The financial situation of the schools of public health today is not satisfactory. Practically all of them need additional funds even to stabilize current operation. Recently, one of the accredited schools was forced to close because of lack of support. I am sure our chairman recognizes that that school was at Vanderbilt; a very fine school.

Only a few years ago another school was discontinued for the same reason. This year several schools report deficits ranging from $50,000 to $290,000. Obviously, new funds must be obtained in order to continue satisfactory operation during 1950 and subsequent years.

If these schools are to increase the supply of the Nation's health specialists, they must have additional financial support. Without this support, they cannot provide the teaching staff, the space, and the equipment essential to the expansion obviously required.

A preliminary study of the financial requirements of the schools was recently made to determine how the Government might help most effectively to stabilize and insure present operations and to increase the future output of specialists without decreasing the quality of their instruction. Reports from the deans of the nine schools show the total operating expenses to be about as follows: 1948, $2,640,000; 1949, $2,997,000; 1950, $3,275,000. The approximate distribution of these costs is as follows: direct institutional costs, 74 percent; administrative and general expenses, 14 percent; plant operation and maintenance, 11 percent; libraries, 1 percent. These figures do not include the cost of special research projects, estimated at a million and a half for the fiscal year 1949.

The income with which to meet these basic expenses is derived from various sources of which tuition is a relatively minor item. In 1950 the average annual income from tuition will be about $440 per student. The cost per student will be approximately $4,500. Thus, tuition covers only about 10 percent of the total educational operating expenses.

Other sources of income are State appropriations, endowment, and various temporary and restricted gifts for current use. The latter must be continually replaced in order to keep the schools running. To secure replacements puts undue demands on the time of our teaching staffs, and constitutes a difficult and precarious method for keeping these schools in operation.

A careful audit of the financial situation of each school will be required to determine its exact operational needs. However, from current reports submitted by the deans within the last few months, it appears that most of the schools will require additional funds for future operation whether at present levels or under a program of expansion.

Whatever the situation in the future, it seems reasonable that the Federal Government should assist in financing the schools of public health.

First, all the schools including those receiving State funds, draw their students from the country as a whole. Second, about 80 percent of the graduates of our schools enter Government service. Most of the others serve voluntary agencies, entire industries, labor organizations or educational institutions.

In determining the amount of assistance required, it should be kept in mind that the financial needs of schools of public health differ considerably from those of the medical schools. Therefore, any plan for Federal support should provide a different formula for making aid available.

The annual cost of public-health training is greater than the cost of medical instruction on a per capita basis. The public-health student requires an intensive postgraduate type of instruction; it must be individualized according to the varying needs and background of the student. The students, most of whom are already medical-school graduates, must be taught in small groups on a similar basis. Much material from medical, engineering, education, and other diverse disciplines must be packed into a single year of training.

All these factors increase the expense of public-health training. Since tuition covers only one-tenth of the operating cost the addition of more students without increased financial assistance with only aggravate an already difficult situation.

Various methods have been proposed for providing the schools of public health with funds to meet their obligations to the future health of the Nation. House bills 4312, 4313, and 3894 now being considered at this hearing provide aid as follows:

> To each school of public health which provides training leading to a graduate degree in fields relating to public health, including hospital administration, $350 per each student enrolled for such training up to its average base enrollment, and $2,400 for each student so enrolled in excess of its average base enrollment.

The base enrollment is to be an average of the three fiscal years 1947–49. Application to this formula, will of course, assist the schools, but is not considered adequate to solve their financial difficulties because of the relatively small amount which it provides for each student within the average base enrollment.

It should also be noted that the 3 years selected for determining average base enrollment represents a period during which considerable expansion has already been made without a comparable increase in the resources of the schools.

The provisions for construction and for scholarships in this bill appear to be adequate.

At a recent meeting of the deans of the accredited schools of public health, a formula for Federal financial assistance was developed which was considered satisfactory both from the standpoint of the Government and of the schools. This formula provided a per capita grant for an average number of students, a premium for additional students, and a block grant. Something approaching this formula is necessary to meet our needs, but it is realized that the application of any formula will require a careful study of the present and future financial requirements of the schools.

In addition to funds for basic educational operations, the nine schools of public health will need money for the construction required to expand their training facilities. An estimate was made recently by the deans indicating that a building program costing approximately $20,000,000 would permit these schools to double present enrollment. Provisions for construction are made in H. R. 4312, 4313, and 3894. To meet the existing needs of the schools, it is felt that both bills should include these provisions on at least a matching basis.

Scholarships are needed so that more students can take postgraduate training in schools of public health.

State health officers are now authorized to pay tuition, travel, stipend up to full salary of position for which employed, and all costs incident to the training of personnel employed or to be employed in official State and local health agencies. However, such assistance is only available for State-sponsored training, and additional provisions are needed for the training of public health workers not eligible under this authorization.

The amounts of the scholarships for students in schools of public health should be larger than those for medical students. The average public health student is older than the average medical, dental, or nursing student. He has already had 4 years of medicine, 1 year of internship and 1 year of residency before even applying for admission to our schools. As a rule he is married, has a family, and considerable financial responsibility. Few public health students can even afford to pay their own tuition. Therefore an adequate scholarship should be provided.

The establishment of a loan fund will not solve this problem. As a public servant, the public health graduate cannot expect a substantial increase in earning power even as a result of his advanced training. He has little hope of repaying substantial loans. Unless money is made available in the form of scholarships or grants, there will probably be no increase in the number of applicants for postgraduate training.

The scholarship provisions indicated in H. R. 4312, 4313, and 3894 are considered adequate.

In conclusion, may I state that the schools of public health are eager to assist in the development of a national public health program, particularly in training the expert health personnel which will be required. To perform this service the schools must have considerable additional annual income to expand their basic educational activities and capital funds for essential construction and equipment. Because of the nature of the science of public health, and the background required by its personnel, costs of instruction and training are higher than in any comparable profession.

It is a fact that the schools of public health will be unable to accomplish the training of personnel required for any one of the public health programs now being considered by the Congress unless adequate Government aid is assured.

Unless this training is provided by our schools, the health of the people of this country will rest in the hands of personnel inadequate in numbers and deficient in training.

Specifically, the Association of Schools of Public Health makes the following recommendations:

First. That provisions be made for a study of the manpower requirements in the public health profession, the training facilities, and the financial needs of the schools of public health.

Second. That provisions be made for immediate interim or temporary payments to the schools of public health to enable them to maintain and increase enrollment during the period of the proposed study; this aid to be based on whatever formula meets the basic needs of the schools, and is acceptable to the Congress. I have commented, sir, on the various formulas involved.

Third. That in the development of a permanent program of aid to public health education, the schools of public health which provide graduate training leading to degrees, including hospital administration, be given funds sufficient to meet the demands to which they will be subjected by whatever public health program is adopted by the Congress.

Fourth. That there also be authorized, based on the proposed study, sufficient funds to provide the modern equipment and construction for the necessary improvement and expansion of existing facilities, and that these grants be authorized on a matching basis in accordance with needs of the schools concerned.

Fifth. That both the immediate and long-range programs of aid include provisions for Federal scholarships to graduate students in public health, including those not already holding positions in Government health departments; these scholarships to cover normal cost of tuition, educational fees, books and equipment, and also to cover the costs of personal maintenance in whatever amount may be determined as the median for single students and students with dependents.

In closing, may I express to the members of this committee and to the Congress my personal appreciation and the appreciation of the Association of Schools of Public Health, for the opportunity to present their opinions and recommendations. We are willing and eager to extend our services and to do everything possible to forward our joint objective of advancing the health of the people of the United States.

I would like to invite your attention to six exhibits attached to this testimony. First is a study of the national need for health workers and provision for adequate facilities for postgraduate training in schools of public health to meet that estimated need. This is the result of a summarization, prepared with the help of experts of the Public Health Service at the request of our association, of materials sent them by the various deans of the individual schools.

The second exhibit is based on the same source of material and the same group of workers, Financial Data on Schools of Public Health.

Third is a proposed formula for Federal aid to schools of public health which was drawn up at a meeting of the deans and was proposed at the previous hearing of the Senate on the bill S. 522.

Exhibit 4 is a little résumé which is intended to give a general idea of the scope of research carried on in schools of public health, and I might mention here so that the cost of research projects is not included in our basic estimates of operating cost for education. It is difficult to draw a line between the two, because of the differing school needs. Every school needs research, but we have arbitrarily eliminated grants in aid for research from the basic teaching of operational costs in the making of these estimates.

The fifth is a statement pertaining to the recruitment of public health personnel and, sixth, is an estimate of the cost to the United States of applying the "cost for instruction" formula outlined in these bills for aid to schools of public health.

That is all, sir.

(The exhibits are as follows:)

Exhibit I

[Fact sheet]

National Need for Trained Public Health Workers and Provision of Adequate Facilities for Advanced Postgraduate Training by Schools of Public Health

(Prepared at the request of the Association of Schools of Public Health by representatives of the USPHS in cooperation with the deans of the accredited schools and other professional groups)

1. Approved schools of public health

(*a*) In 1930 there were only four schools or departments (Columbia, Harvard, Johns Hopkins, Yale) in existence which later were fully accredited when the American Public Health Association (APHA) inaugurated an accreditation program in 1945.

(*b*) There are today nine approved schools or departments in the continental United States (California, Columbia, Harvard, Johns Hopkins, Michigan, Minnesota, North Carolina, Tulane, Yale). Vanderbilt University had an approved school until the 1948–49 academic year when it was discontinued for lack of funds.

2. Training data on schools of public health

(*a*) The number of graduate students enrolled in the approved schools in the United States during the 1947–48 academic year was 655.

(*b*) The number of graduates of schools of public health (approved and nonapproved):

Academic year:	*Number*
1930–31	119
1934–35	113
1939–40	303
1945–46	323
1946–47	453
1947–48	444
1948–49 (estimate)	450
1949–50 (estimate)	450
1950–51 (estimate)	450

(*c*) Length of course:

(1) One year of study generally is required for the master's degree. Two years are required for the master's degree in hospital administration. Two years are required at Harvard and Johns Hopkins for the master of science in hygiene degree.

(2) Two to three years generally are required for doctoral degrees in public health depending on the qualifications of the individual candidates.

3. Estimated number of full-time public health workers now active in the United States.

	Year 1949
(*a*) Total (all professions)	35,800
(1) Medical	2,700
(2) Nursing	22,000
(3) Engineering	1,100
(4) Sanitation	5,500
(5) Dental	360
(6) Health education	890
(7) Laboratory	3,250
(*b*) Number of above total in official public health agencies	29,500
(*c*) Number in voluntary public health agencies	6,300

4. Number of full-time trained public health workers needed by the United States in 1960 [1]

	Year 1960
Total (all professions)	68,300
(1) Medical	5,000
(2) Nursing	[1] 35,500
(3) Engineering	3,300
(4) Sanitation	10,700
(5) Dental	1,450
(6) Health education	3,550
(7) Laboratory	8,800

[1] This figure should be doubled if a comprehensive nursing service, including bedside care, is to be provided.

The total, 68,300, is the number of health workers who should be on the job in 1960 in order to meet the needs outlined in the attached footnote. To provide this number of active workers in 1960, it will be necessary to train a total of 77,530 in order to make up for training deficiencies of existing personnel and to cover local personnel turn-over.

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[1] Based on estimated population of 160 million and complete coverage of United States with local health units. Ratios for physicians and nurses are those recommended by APHA; others are based on standards recommended by experts in the respective fields. See explanatory note.

The following table shows the basis of the future training load to supply 68, 300 active trained public health workers in 1960.

	New personnel		Estimated present employees needing further training	Total, 10-year period
	Estimated deficiency	Estimated replacements		
Medical	2, 300	1, 350	1, 750	5, 400
Nursing	13, 500	22, 000	15, 180	50, 680
Engineering	2, 200	330	220	2, 750
Sanitation [1]	1, 040	1, 650	830	3, 520
Dental	1, 090	180	240	1, 510
Health education	2, 660	450	300	3, 410
Laboratory	5, 550	3, 900	810	10, 260
Total	28, 340	29, 860	19, 330	77, 530

[1] Only 20 percent of the number of sanitarians now employed are used in computing training needs for sanitarians, since it is believed that only this fraction constitutes a training problem for professional schools.

5. *Full-time health workers to be trained by schools of public health*

Thirty percent, or 23,250, of the 77,530 workers to be trained by 1960 should have advanced postgraduate training in schools of public health. This includes all of the physicians and dentists needed, but only a varying proportion, in some instances quite small, of the other professional groups.

It should be noted that these figures do not include estimated needs for hospital administrators, medical-care directors, nutritionists, statisticians, veterinarians, and other important specialists concerned with public health work. This is because no bases similar to those for the classes listed above have yet been developed for estimating future needs for personnel of these special types. Therefore, the total requirement for 1960 will probably be even greater than 23,250.

6. *Estimate of the expansion of present training facilities of approved schools of public health required to meet this goal in 1960*

This year, 1948–49, the combined enrollment of the accredited schools of public health is about 800 students, of which about 450 are candidates for degrees or certificates. Another school is being developed at the University of Pittsburg and will probably be operating by 1951. It is estimated that with adequate financial assistance for teaching staff, equipment, and construction, these 10 schools might conceivably expand sufficiently to take care of the training of the required 22,800 students if enrollment is increased gradually to about 3,000 per year by 1959–60, as shown in the following table:

Academic year:	*Enrollment*
1948–49	800
1949–50	1, 000
1950–51	1, 200
1951–52	1, 400
1952–53	1, 600
1953–54	1, 800
1954–55	2, 000
Academic year—Continued	*Enrollment*
1955–56	2, 200
1956–57	2, 400
1957–58	2, 600
1958–59	2, 800
1959–60	3, 000
Total	22, 800

To reach this figure would require an average enrollment for each of the 10 schools of about 300 per annum by the academic year 1959–60. As their ability to reach this degree of expansion is subject to question, consideration should be given to the possibility of establishing a limited number of additional schools of the high professional quality suitable for accreditation. Some of these additional schools might specialize in the postgraduate training of nonmedical health workers.

[Explanatory note]

ESTIMATED REQUESTS FOR VARIOUS TYPES OF FULL-TIME HEALTH PERSONNEL TO SERVE THE UNITED STATES BY 1960

The estimates shown in the previous tables are based on an estimated 1960 population of 160,000,000. They assume complete coverage of the United States by local health units serving areas of sufficient population and financial resources for economical operation. They are based only on full-time personnel. The standards used as a basis for these estimates were as follows: (the ratios for physicians and nurses are those recommended by APHA; the others are unofficial standards recommended by people of recognized standing in the respective fields):

One public health physician for every 50,000 population except that each local health unit will have at least one public health physician (plus State needs arrived at by projecting the ratio of public health physicians to population in the 12 States most adequately staffed to the entire country, plus a modest increase for Federal personnel).

One staff public health nurse for every 5,000 population and 1 supervisory nurse to every 10 staff nurses for basis of public health nursing service at both State and local level (plus a modest increase in Federal personnel).

One sanitary engineer for every 60,000 population (plus State and Federal needs as computed for physicians).

One sanitation worker for every 15,000 population (except that each local health unit will have one trained sanitarian, plus State and Federal needs as computed for physicians).

One public health dentist to every 100,000 (however, it is assumed that units under 50,000 population will not have a full-time dentist and that a number of the units serving populations of 50,000 to 80,000 will combine to use the services of a single dentist).

One health educator for every 50,000 population (plus State and Federal needs as computed for physicians).

One laboratory worker for every 20,000 population (to serve both State and local needs plus a modest increase in Federal personnel).

EXHIBIT II

FINANCIAL DATA ON ACCREDITED SCHOOLS AND DEPARTMENTS OF PUBLIC HEALTH IN THE UNITED STATES

(Prepared at the request of the Association of Schools of Public Health by representatives of the USPHS in cooperation with the deans of the accredited schools and other professional groups)

A. Costs of operating the schools of public health

TABLE I.—*Total educational operating expenses (not including research grants), graduate schools of public health, fiscal years 1948, 1949, and 1950*

Function	Total expenses		
	Fiscal year 1948	Fiscal year 1949	Fiscal year 1950
Instructional costs	$1,916,746	$2,193,518	$2,429,288
Administration and general expenses	375,896	411,834	453,048
Plant operation and maintenance	312,894	356,976	354,110
Libraries	35,812	35,437	35,982
Total	2,641,348	2,997,765	3,272,428

TABLE II.—*Percentage distribution of total educational operating expenses, graduate schools of public health, fiscal years 1948, 1949, and 1950*

Function	Percentage of total educational operating expenses		
	Fiscal year 1948	Fiscal year 1949	Fiscal year 1950
Instructional costs	72.6	73.2	74.2
Administration and general expenses	14.2	13.7	13.9
Plant operation and maintenance	11.8	11.9	10.8
Libraries	1.4	1.2	1.1
Total	100.0	100.0	100.0

A high percentage of the total operating expense (nearly 75 percent) is devoted to the productive function of instruction. This cost is irreducible if quality of training is to be maintained and if good teachers are to be attracted to teaching.

B. Sources of funds to meet operating expenses

In fiscal year 1948 student tuition and fees provided $291,933, or 11.1 percent of the total operating expenses of the schools of public health. Receipts from student tuition and fees during the present fiscal year will total only $312,930, or 10.4 percent of the educational operating expenses of the schools. It is estimated that the funds from student tuition and fees will not increase in fiscal year 1950, as the number of enrollees will be approximately the same as in fiscal year 1949.

The other sources of income are State appropriations, income from endowments, general university funds, and a number of small temporary gifts and grants for current use which expire in one, two, three, or more years and must be constantly replaced in order to keep the schools running.

Privately supported schools.—There are five privately supported schools—Harvard, Columbia, Johns Hopkins, Yale, and Tulane. Table III indicates the degree to which the operating costs of these private schools are met from the major sources of income.

TABLE III.—*Sources of income, privately supported schools, fiscal years 1948, 1949, and 1950*

Source of funds	Percentage of total educational operating expenses		
	Fiscal year 1948	Fiscal year 1949	Fiscal year 1950
Endowment income	35	31	32
General university funds	26	22	27
Temporary gifts and grants	25	34	27
Tuition and fees and miscellaneous	14	13	14
Total	100	100	100

The reported dollar contributions from general university funds and from the temporary gifts and grants are very considerable (51 to 56 percent of total income), and, as these sources are inconstant and tend to disappear, they are a difficult and uncertain method of insuring the future. Table IV indicates the part that the sources of funds play in meeting the operating expenses on a per student basis.

TABLE IV.—*Per student averages: Privately supported schools*

Fiscal year	Operating expense: Average annual operating expense per graduate student	Sources of income		
		Average annual income per student from tuition and fees	Average annual income per student from general university funds and temporary gifts and grants	Average annual income per student from all other sources
1949	$4,495	$447	$2,494	$1,554
1950	4,934	447	2,390	2,097

Endowed schools are presently experiencing difficulty in obtaining gifts and grants for instructional purposes and the schools of public health are receiving more than their proportionate share of university general funds. Unless new funds are made available, these schools will be faced with the alternative of either seriously curtailing their teaching program or spending their capital.

This situation at endowed schools is particularly serious at a time when the schools should be expanding not only in the scope of the instruction offered, but in the number of students trained.

State-supported schools.—The schools of North Carolina, California, Minnesota, and Michigan receive income primarily from State appropriations. Table V estimates the degree to which the operating costs of these State schools are met from the major sources of income.

TABLE V.—*Source of income: State supported schools, fiscal years 1949 and 1950*

Source of funds	Percentage of total educational operating expenses	
	Fiscal year 1949	Fiscal year 1950
State appropriations	79	80
Tuition and fees	11	10
Gifts and grants and endowment	10	10
Total	100	100

Table VI estimates the part that the sources of funds play in meeting the operating expenses on a per-student basis.

TABLE VI.—*Per student averages: State-supported schools*

Fiscal year	Operating expense: Average annual operating expenses per graduate student	Sources of income		
		Average annual income per student from tuition and fees	Average annual income per student from State appropriations	Average annual income per student from all other sources
1949	$3,603	$404	$2,840	$359
1950	3,896	404	3,121	371

C. Building costs to meet proposed expansion program of the schools [1]

TABLE VII. *Cost of building program*

Harvard University	$4,500,000
The Johns Hopkins University	4,000,000
University of Michigan	3,000,000
Columbia University	3,000,000
University of California	2,250,000
University of North Carolina	1,500,000
Tulane University	425,000
University of Minnesota	350,000
Yale University	(1)
Total	19,025,000

[1] New building needed; no estimate of cost available.

D. Additional statements on proposed expansion programs of the schools

(*a*) *University of California.*—They are now housed in temporary quarters. They will need at least to double the California State Legislature's appropriation of $1,125,000 for their building fund if they are to carry their share and serve some 11 Western States and the neighboring nations. It is felt that Federal aid is absolutely necessary for this development.

(*b*) *Columbia University.*—Regarding additional needs, they have had plans tentatively drawn for a building program to house their activities in the School of Public Health which would cost approximately $3,000,000. In addition their operational budget would increase the enrollment to approximately 250 graduate students.

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[1] This program would permit an over-all doubling of present enrollment of all schools; however, it would fall far short of 1960 needs.

(*c*) *Harvard University.*—Expansion program provides for training of from 150 to 200 students. In order to meet these needs the school has proposed to the university a financial program extending over a period of several years. In this program it is proposed to try to raise sufficient endowment so that the fixed income of the school will cover its fixed expenses. It is estimated that at least $12,000,000 additional endowment will be required to do this. It is also proposed that in order to house the expanded activities of the school 4½ to 5 million dollars be obtained from some source with which to construct a modern building.

(*d*) *Johns Hopkins University.*—The school estimates that to adequately meet the needs of the present number of students admitted to the school additional construction is necessary at the present time. School estimates construction needs to meet the space requirements of the present enrollment of the school in terms of a building costing approximately $750,000. They estimate need, in order to provide adequately for the present group, of an increase in the operating budget of approximately $100,000 per year over and above the existing operating budget. If the enrollment of the school were to be doubled, they estimate their requirement of an approximate duplication of the present facilities at a cost of approximately $4,000,000. Doubling the class would, they believe, increase the operating budget by no less than $300,000 per year.

(*e*) *University of Michigan.*—Preliminary sketches are available for an addition to the school plant which will more than double the present capacity, with special emphasis upon laboratories in the fields of industry health, sanitation, nutrition and the important problems dealing with the aging process. Such an addition will permit an increase in the enrollment of approximately 250 graduate students. It is estimated that the new building, together with equipment, would cost approximately $3,000,000.

(*f*) *University of Minnesota.*—As an essential first step in expanding the capacity of the School of Public Health at Minnesota, it is estimated that at least $200,000 per annum will be needed to meet the increased instructional program to be offered, and $350,000 will be needed for a building program to house the expanded activities of the school,

(*g*) *University of North Carolina.*—The university recognized the urgency of expansion of physical facilities to meet present as well as future public health training and has appropriated money for one wing of the new School of Public Health building which is now under construction and will be completed by July 1. They have given primary priority in their request to the North Carolina Legislature for building appropriations to complete the new School of Public Health at an estimated cost of $1,500,000 dependent upon Federal participation in the cost of construction. Such a Federal appropriation is necessary considering the large proportion of students of public health who come from and go to other States following their training in this institution.

With the completion of this new school of public health the quota of students can be increased to a total of 200 students. Such a program calls for roughly an increased annual teaching appropriation beyond present appropriations of approximately $300,000. With the probability that the proportion of North Carolina students served by this institution will not increase, it is obvious that the majority of this increased cost will have to be met by other agencies than the North Carolina Legislature.

(*h*) *Tulane University.*—In a proposed expansion of the entire school, the expansion for the department of tropical medicine and public health of about 13,500 square feet would cost approximately $275,000, and with this expansion the equipment would cost about $150,000. This would allow the school to take approximately 45 students instead of the 23 which they now have, with an increase in instructional cost of about $49,200.

(*i*) *Yale University.*—The school estimates that in addition to the new building the minimum they will require to meet their expansion goal will be $90,000. This will be needed for instructional costs, especially for biostatistics, medical nutrition, hospital and medical care, occupational medicine, epidemiology, housing, maternal and child health, and overhead costs. This would permit more effective work and expansion in enrollment of 30 to 40 percent.

E. Residence of students

Since approximately 68 percent of the sutdents enrolled in the schools of public health come from States and countries other than the States in which the schools are located, and further, since the graduate students are being trained primarily for public service, it is felt that the Federal Government should share in the cost of this educational process. Table VIII shows the distribution of the current student load in these schools according to State or country of residence.

TABLE VIII

School	State residents	Residents of other States	Foreign nationals	Total students
California	50	17	7	74
Columbia	48	54	16	118
Harvard	30	45	28	103
Johns Hopkins	9	66	47	122
Michigan	22	34	15	71
Minnesota	36	32	16	84
North Carolina	20	44	15	79
Tulane	5	12	12	29
Yale	7	25	8	40
Total	227	329	164	720

EXHIBIT III

PROPOSED FORMULA FOR FEDERAL ASSISTANCE TO ACCREDITED SCHOOLS AND DEPARTMENTS OF PUBLIC HEALTH

(Developed at a meeting of the deans of the nine accredited schools of public health in the continental United States during January 1949)

(1) Determine the basic cost of operating the accredited program of the schools of public health, excluding funds obtained from other Federal grants and so-called project research funds.

(2) The Government to make a block grant amounting to one-half of the amount determined under paragraph (1), but not to exceed $250,000 per annum for each school.

(3) Grants per student:

(*a*) The Government to pay to the school $1,200 for each graduate student up to a base line of enrollment to be determined from some type of average enrollment in previous years.

(*b*) $2,400 per graduate student above that base line of enrollment.

(4) In order to discourage the development of "wildcat" schools, the total of the block grant (par. 2), plus the per capita grant (par. 3) could not exceed the basic cost of operating the school (par. 1), so that the amount provided by the Federal Government would never exceed the amount (par. 1) already provided by the school.

As pointed out, the application of this formula will require (1) a careful survey and analysis of the operating costs of schools of public health and (2) the development of various technical details to administer the program properly.

EXHIBIT IV

RESEARCH IN SCHOOLS OF PUBLIC HEALTH

Research in our schools of public health strikes at the heart of disease prevention, using methods all the way from basic scientific laboratory investigations to large-scale field experiments in disease control. These schools are attacking epidemic disease threats like typhus and poliomyelitis. They have many researches under way against devastating nervous diseases such as the sleeping sickness encephalitis and the crippling killer, multiple sclerosis.

The schools of public health are working on the great problems of the common cold and influenza. They are searching to find how immunity to many diseases can be developed within the human body. Veneral-disease control is one of their major projects. They are now also pioneering in research on degenerative diseases such as heart diseases, arteriosclerosis, diabetes, and cancer; they are seeking the basic information needed to control these important causes of human suffering.

Costs of medical care will go down as we learn how to build healthy minds and healthy bodies. Our schools of public health have undertaken mental-health projects and studies of social factors affecting the health of the mind. These schools lead in developing the body-building science of nutrition; here research problems in human nutrition extend from the unborn infant, through the stages of childhood, all the way to old age. Indeed, work now under way in these schools on the problem of aging undoubtedly belongs in one of the most important of all research fields.

Our Government is counting on the schools of public health for research to guard against the hazards involved in atomic energy development. They are making investigations for our armed forces on such problems as the food, clothing, shelter, and health-protection requirements which will make troops more effective in Arctic climates. They are tackling control of malaria, the chief disabling disease of our troops in the Tropics, as well as many other problems of tropic diseases which affect our troops and the welfare of many nations we count as friends.

Both industry and labor benefit by the studies of our schools of public health, such as those dealing with control of accidents, now the fourth leading cause of death, and of industrial hazards, such as the poisonings and contaminations which follow chemical and technological advances. The iron lung resulted from industrial health research in a school of public health, and a new device for resuscitation by electrical stimulation of the phrenic nerve is now being developed.

Finally, these schools are improving public health by many special studies, such as effective methods for getting health knowledge to all the people through out public schools and popular education; investigation of the social and economic problem of medical practice; evaluation of labor-union health, public-health nursing, and crippled children programs, and researches dealing with wide use of X-ray and other diagnostic methods and of great new weapons against disease such as penicillin and other antibiotics.

Any program adopted for the expansion of the schools of public health should include adequate provision for the continuation and expansion of their research activities.

Exhibit V

Recruitment of Public Health Personnel

In a recent report on the schools of public health during 1948–49, made by Dr. C. E. A. Winslow, consultant to the committee on professional education, American Public Health Association, an analysis of the master of public health student body of the accredited schools was presented. Dr. Winslow called attention to the fact that there were 331 candidates for this degree this year, as compared with 444 last year.

He also stated that over half of the students registered for MPH are physicians, with 8 dentists and 14 veterinarians. One hundred and seventy-four are qualified by a year of academic instruction following their bachelor's degree, or 3 years' experience, or both. He emphasized the urgent need for medical MPH graduates to fill top administrative posts. A further analysis of the 235 medical men shows that 43 percent of these candiates are foreign students, and of the native students the majority are men already in public service or in the Army or the Navy.

Dr. Winslow remarked that it is highly desirable, of course, to give postgraduate training to physicians already in the public-health field to fit them better for their tasks. By further filling of new posts, we have only 38 new medical recruits in all the 10 schools of public health. He also showed that more than half of this year's medical candidates for the MPH degree took their medical degrees more than 10 years ago, and that only 37 graduated within the last 4 years. He concludes that young physicians are not being attracted to the field of public health in any appreciable degree, and in the nonmedical field the 174 MPH students now registered are quite inadequate to meet the needs.

The remedy for this situation must be approached along two lines—increase in salaries for public-health posts to make those posts more attractive—and more active recruitment in our educational institutions. In the latter approach, the schools themselves have a definite and direct responsibility.

EXHIBIT VI

ESTIMATED COST TO THE GOVERNMENT OF APPLYING "COSTS OF INSTRUCTION" FORMULA FOR SCHOOLS OF PUBLIC HEALTH PROPOSED IN H. R. 4312, 4313, AND 3894

Proposed formula

1. $350 per student up to average base for 1946–47, 1947–48, 1948–49.
2. $2,400 per student in excess of average base number.

Application of formula

Determine:

1. Average base enrolled in all accredited schools of public health:

(*a*) Total enrollment 1946–47	687
(*b*) Total enrollment 1947–48	655
(*c*) Total enrollment 1948–49	800
Total	2, 800
Average	714

2. Apply formula to estimated needs for training in schools of public health (exhibit I). Use round-number average of 700.

	Need	Cost for average	Cost for excess	Total cost
1949–50	1, 000	$245, 000	$720, 000	$965, 000
1950–51	1, 200	245, 000	1, 200, 000	1, 445, 000
1951–52	1, 400	245, 000	1, 680, 000	1, 725, 000
1952–53	1, 600	245, 000	2, 160, 000	2, 405, 000
1953–54	1, 800	245, 000	2, 640, 000	2, 885, 000
1954–55	2, 000	245, 000	3, 120, 000	3, 365, 000
1955–56	2, 200	245, 000	3, 600, 000	3, 855, 000

Annual cost to Government increasing from $965,000 for year 1949–50 to $3,855,000 for year 1955–56.

	Need	Cost for average	Cost for excess	Total cost
1959–60	3, 000	$245, 000	$5, 520, 000	$5, 765, 000

Mr. PRIEST. General, we really appreciate very much this very complete statement with all of the exhibits. I note, for example, in exhibit 6, the one that you referred to in the proposed formula, $350 per student up to the average base of 1947–48–49, and the amount in excess of the average base number. The formula in the bill for regular medical assistance in that respect is slightly different, particularly the amount that would be available for students in excess of the average base amount.

Do you believe that this formula has been pretty well worked out on the basis of studies, and that this is its logical requirement?

General SIMMONS. No, sir. I am not entirely satisfied with that formula, and that is the reason that I have suggested that we have a study even before the temporary formula is adopted. One thing that I object to, if I may say so, is that I think the rate for average students, while it will help the schools of public health, just as the $300 rate will help medical schools, is not high enough to help solve our real difficulties. I think that the average rate should be raised, and possibly the premium rate left at the same point.

As you can see from our fix here, with our cost per student being so much higher, possibly estimated at almost twice what it is for medical students, neither one of these figures approximates our cost per student, and, of course, we would not expect the Government to take the whole thing over because that would be running a Government school, but I do think that it should be somewhat higher, sir.

Mr. Priest. Most of your students are in the graduate class, are they not?

General Simmons. Yes. Practically all of them are graduates already in medicine, and they have had a year's internship and residency, and some of them 2 or 3 years' service in the field. So they are older people, and they come into the scholarship field with greater responsibilities. A great many of them have families and children, and so the scholarships would be a little different, too, as far as need is concerned.

Mr. Priest. Are there any other questions?

Mr. Biemiller. I just want to add to the remarks that you have made. I do not remember when I have seen such a fine presentation, with the supporting data, particularly, and I appreciate its being in the statement. It is the first time that I can remember, Mr. Chairman, that I expected to ask for certain data and found it was all here before I asked for it, which is a very pleasant and gratifying surprise.

I would like to raise one question that has come up two or three times by inference in our discussions of this bill, and particularly, I believe, is pertinent to the discussion on the public health schools.

You, yourself, General, make reference to the fact that you render a service comparable to West Point and Annapolis. I think that that is very true; the majority of your graduates are going into Government service of one type or another.

Now, the suggestion keeps going around the Congress that maybe what we should do, instead of giving grants to established schools, is that the Government should establish a West Point for medical students, and particularly for public health people.

Would you care to comment on that?

General Simmons. I would not object to that, but I doubt whether it could be done. It would have to be a university, because our needs are so great. One school would not meet the need. We had something comparable to that in the Army Medical School before the war, and we had training courses there in military preventive medicine which, although they were aimed at the military need, in reality approached the objectives of our present schools of public health. Of course, it was not quite so broad, but it was something along that line.

Fifteen years ago in the Army I had the idea that you have now, about the possibility of making that into a national institution, but I do not believe that will meet the needs that are before us now.

Mr. Biemiller. I quite agree, and I do not want to give you the inference that I am in favor of such a proposal, but it has been discussed.

General Simmons. I think we need more physically than we could house in one institution.

Mr. Biemiller. I am a great believer in that there is value in the diversification that you get in terms of geographical areas.

General Simmons. There is no question about that. I mentioned the fact that the teaching programs vary considerably in these accredited schools. For example, the University of Minneosta—first I should say that all of them have a main objective, which is the training leading to the doctor of public health degree, but then there is variation in the specialties aside from that.

For example, Minneosta specializes in training public health nurses, and they are doing a swell job of it. Our school does not do that. We may go into it later.

North Carolina specializes also on the side in training what we call public health educators, or people to educate the general public in the principle of public health. I think that there is an advantage in having these different objectives and these different schools. They all add up to something.

Mr. Biemiller. I think that that is a very valuable thing, and one more point: I did not notice any statements in your testimony about concern that maybe the Surgeon General might be hamstringing you if we developed this program.

General Simmons. Mr. Bielmiller, I would be as concerned as any other American citizen if I though there was any chance of loss of the freedom of schools to do what they think is right in the instruction and education of the students. But I have not the slightest fear of the thing about which you are speaking, because I have more faith in the American system, and I think that we can control the Surgeon General if he wants to step out of line. I do not think any man would dare to do that except under a dictatorship.

Mr. Biemiller. I am glad to say that, because I concur heartily in the view you have expressed.

Mr. Sadowski. The fear was also expressed, General, that, by obtaining these Federal funds, private funds and private donations will slow down. Do you agree with that?

General Simmons. I am glad that there was thought on this question, because I want to make the point that, with Federal aid, we hope they do not fall off, though I am afraid there will be a tendency in that direction, because what we are trying to do is supplement our need rather than to replace it. Does that answer your question?

Mr. Sadowski. It satisfied me, but some of the witnesses that have appeared before the committee felt that, once we embark upon this program, gradually all of the schools will become dependent on Federal aid exclusively.

General Simmons. I do not believe that. At least I couldn't believe that will necessarily hold true, though, of course, I do not know anymore about that than do you.

I think that there will be a decrease, possibly, on that basis until we restate our needs to our private helpers, but there has already been a decrease. I am talking about the temporary funds.

For example, our budget at the Harvard School of Public Health this year is double what it was in 1946 when the school was reorganized, and I retired from the Army and went there as dean. We have a budget of $877,000. Of that, only 24 percent was what I would consider as fairly firm, or semifirm, money. About $170,000 of it is income from endowments. About $40,000 is income from tuitions. The rest of that money is soft money, consisting of temporary small grants that I have gone out and begged for with a tin cup in my hand from various donors to keep the school running.

Most of these run out in 1 year, some in 2 or 3 years, and it means that we have to continually go back and beg for that. Those sources are not giving down so freely as they did 3 years ago. It is always a precarious thing as to whether they might dry up entirely. I have therefore presented to the Harvard Corp. a 1-year program which they have O. K.'d for me to carry out, trying to get $12,000,000 in endowments so that we can increase our firm income in order that we may equal our continuing basic expenditures. I may not get it, but the thing is that we need help right now, and I would like to have six additional professors this year, and we cannot get them. All of the schools are in the same fix.

Mr. SADOWSKI. I believe that one of the witnesses stated that in his opinion in no case should there be a greater amount of Federal assistance given than 30 percent. Would you agree with that?

General SIMMONS. I am inclined to. We were thinking of recommending 50 percent, but I am inclined to think that that is right, because there are schools, I believe, sir, that will not be able to match 50 percent, and I think it would be very bad if we lose anymore schools as we have Vanderbilt, and I am hoping that they come back into the picture if aid comes.

Mr. PRIEST. I certainly hope so.

Are there any other questions?

Mr. WOLVERTON. I have no questions.

General SIMMONS. Could I add one word? I presented exactly the same testimony to the Senate committee on the 7th of June, and this is changed only in reference to your bills. At that time Senator Murray received a telegram from Mr. Conant stating that he sponsored what I was saying; and I received a letter from Dr. Wriston, the president of the Association of American Universities, saying that he also sponsored my testimony; and I wondered whether it would be appropriate to make that statement in connection with this statement.

Mr. PRIEST. We would be happy to have a copy of the telegram or letter, if you care to offer them for the record.

At the same time, the Chair has here a telegram addressed to the chairman of the committee, Mr. Crosser, from Dr. Edward G. McGavran, dean of the School of Public Health of North Carolina, in which he regrets his inability to appear as a witness but endorses everything which he understands you will say before the committee, General.

Without objection, this telegram will be placed in the record at this point with your two documents, sir.

(The information is as follows:)

[Telegram]

JUNE 6, 1949.

Senator JAMES E. MURRAY,
Senate Office Building, Washington, D. C.:

I understand that the Senate Committee on Labor and Public Welfare is holding a hearing tomorrow morning on title 1 of Senate bill 1679 and title 6 of Senate bill 1581, at which time Dean J. S. Simmons, of the Harvard School of Public Health, will appear as a witness at 10 o'clock. I should like to advise you that I am generally favorable to Federal aid to medical schools, dental schools, and schools of public health. With particular reference to Dean Simmons' testimony, may I say that I recognize that a formula which will meet the basic needs of these schools is necessary and is a desirable method of procedure in my opinion. I also feel that a study of the needs of the public health schools, so that there may be a better knowledge of their long-term requirements, is most important.

JAMES B. CONANT.

BROWN UNIVERSITY,
Providence, R. I., June 7, 1949.

Brig. Gen. JAMES S. SIMMONS,
Dean, School of Public Health, Harvard University,
Boston 15, Mass.

DEAR GENERAL SIMMONS: I greatly appreciated your thoughtfulness in sending me a copy of your testimony on Federal aid to schools of public health. As I told you on the phone yesterday, your statement represents my general point of view as president of the Association of American Universities with regard to schools of public health, and I am glad to have you testify to that effect.

With kind regards.

Sincerely yours,

HENRY M. WRISTON.

[Telegram]

CHAPEL HILL, N. C., *June 9, 1949.*

Representative ROBERT CROSSER,
Committee on Interstate and Foreign Commerce,
House of Representatives:

Am sorry not to be able to appear as witness along with other deans of the schools of public health at hearings before your committee on title 1 of H. R. 4312, 4313, and 3894. I wish, however, to heartily endorse the testimony being presented by James Stevens Simmons, a copy of which I have been carefully reviewing.

EDWARD G. MCGAVRAN,
Dean, School of Public Health.

Mr. PRIEST. The Chair has also received a letter from Dr. Gaylord Anderson, Mayo professor and director of the School of Public Health of the Medical School at the University of Minnesota, on the same subject.

Without objection, that will go in the record at this point.

(The letter is as follows:)

UNIVERSITY OF MINNESOTA,
THE MEDICAL SCHOOL,
Minneapolis, June 8, 1949.

Hon. ROBERT CROSSER,
Chairman of the Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR REPRESENTATIVE CROSSER: I greatly appreciate the invitation extended to me under recent date to appear as a witness or to file a statement for the record in connection with the hearings on H. R. 4312, 4313, and 3894 which begin tomorrow before the Subcommittee on Public Health, Science, and Commerce. Dr. James S. Simmons, dean of the Harvard School of Public Health, will appear before the subcommittee as a representative of the Association of Schools of Public Health, of which I am secretary. Since it is not possible for me to appear personally because of prior commitments, I am taking the liberty of writing to you in my capacity of director of the School of Public Health at the University of Minnesota, one of the nine accredited schools of public health in continental United States.

Those portions of these bills dealing with aid for training in public health work are identical. My comments which are made with special reference to H. R. 3894 are equally applicable to all three. All provide assistance to educational institutions that furnish training for public-health personnel. I believe this to be essentially sound for two reasons: (1) The students being trained in public health are employed almost exclusively in governmental service or by voluntary agencies rendering services of a community character. The Government has had for many years the principle of training personnel who will serve in defense of the country against enemy invasion. I believe it is equally sound that Government should participate in the training of personnel to protect the country against the invasion of disease. (2) Of the nine accredited schools of public health, five are supported by private philanthropy and four by States, namely, California, Michigan, Minnesota, and North Carolina. These nine schools train students to be employed in all parts of the United States, as well as foreign countries. For example, during the current year, the School of Public Health at the University of Minnesota had students from 30 States and 15 foreign countries. Less than one-third of the students in these schools come from the State in which the school is located. This means that there is currently a very uneven distribution of costs of these schools. Since it is neither educationally sound nor economically advisable that every State should attempt to establish and maintain a school of this character, I believe that Federal assistance is the most desirable method of more equitable distribution of costs.

For the reasons above, I am in hearty accord with the general purpose of the educational sections of these bills.

There are, however, two or three details of the present phraseology which would, I believe, fail to accomplish the obvious purpose of the proposed legislation.

On pages 3, 4, and 5 of H. R. 3894, provision is made for payment to schools of medicine, nursing, public health, etc. This phraseology presupposes a standard pattern of university organization which unfortunately does not exist. Thus, of the nine universities in the continental United States accredited by the American Public Health Association for graduate work in public health, seven are schools of public health and two (Yale and Tulane) are departments of medical schools. Under the strict interpretation of the present phraseology, these two universities would not be eligible for assistance. Similarly, in line 11 of page 4, reference is made to grants to schools of nursing which provide basic or advanced training. This includes public-health nursing. There are currently 33 universities offering accredited programs of study in public-health nursing. While in most of the universities this program is under the school of nursing, there are others such as Minnesota and Michigan in which the program is under the school of public health, and still others such as Columbia which has the program under the college of education. Under the strict interpretation of the present phraseology, those universities having public-health nursing under some other part of the university than the school of nursing might be considered ineligible for assistance, however excellent the quality of instruction, or however large the student enrollment. Of about 1,500 graduate nurses taking the basic program in public-health nursing, but still not classifiable as graduate students under subparagraph 4 of this section, 171 are currently enrolled in the University of Minnesota; yet we might be considered ineligible for any assistance under this bill because our public-health-nursing instruction is a part of the School of Public Health, and these students could not be covered under the heading of "training leading to a graduate degree." May I suggest that in all instances the reference to a particular school or university be deleted and replaced by reference merely to a university or college or similar educational institution. This would permit the institution the desirable degree of freedom as to how it wishes to organize its internal structure. I am certain that such was the intent of the bill.

A further difficulty appears on page 4 in lines 12 and 13 which refers to "basic or advanced training leading to a degree in nursing." I would interpret this to mean that the student must be enrolled in a program which, if completed, would earn for her a degree in nursing. It happens, however, that a large proportion of the nurses taking public-health nursing come to the university from rather small nursing schools where they have had little or no prior instruction at the university level. They are all graduate nurses but their academic credits are so few that there is little possibility of their earning a degree. While at the school, they all take the same basic training in public-health nursing, a training which for the girl who already has sufficient academic credits will complete the requirements for a degree. A higher proportion of the girls who are registered on this basis as adult specials actually go into the practice of public-health nursing than of the girls who have spent their entire nursing career in a university and are rounding it off toward a degree. Were we to specify that the program must lead to a degree, we would thus be excluding the largest proportion of our nurses who are being trained for public-health nursing. I am sure that this is not the purpose of the bill. Could not the purpose of this be covered by providing not that the training lead to a degree in nursing, but that it be offered at the level of a degree course and be made up of courses which count toward a degree?

Paragraph 372C introduces further difficulties, especially as applied to public health and other fields of nursing. During the war there was a large enrollment due to the cadet nursing program. This large enrollment held over into the 3-year period provided in this section. With the termination of the program we have seen a material drop in enrollment. Consequently the average enrollment of these 3 years has been abnormally high. If that artificially high enrollment is used to calculate average past enrollment, this would make it virtually impossible for the schools of nursing and public-health nursing to obtain students which could be counted as new students in excess of average past enrollment.

I hope that the above comments will not be interpreted as criticisms of the basic purpose of the bill with which I am in hearty accord, but rather as constructive suggestions designed to clarify certain points which might otherwise lead to misinterpretation and might even defeat some of the expressed purposes of this legislation.

Very truly yours,

GAYLORD W. ANDERSON, M. D.,
Mayo Professor and Director, School of Public Health.

Mr. PRIEST. We are so happy to have you with us, General.

Without objection, we will insert at this point a statement of Mr. Lloyd C. Halvorson of the National Grange.

(The statement is as follows:)

STATEMENT BY LLOYD C. HALVORSON, ECONOMIST, THE NATIONAL GRANGE, ON H. R. 4312 AND H. R. 4313

1. The National Grange at its 1947 annual session adopted the following resolution on medical personnel:

"Some rural communities need doctors, dentists and nurses.

"Recommendation: Local communities should make their needs known to medical, dental, and nursing societies and take steps to induce doctors and nurses to come. If medical services are not available locally, the community should consider the establishment of ambulance service.

"More doctors, dentists and nurses need to be trained.

"Recommendation: Adequate medical and dental school facilities should be provided by the colleges. Monopolistic abuse in determination if medical and dental school enrollment should be prevented. Medical and dental school scholarships should be provided young people wishing to practice in rural areas. Young women should be encouraged to take up nursing, and training of nurses should include some experience in rural hospitals.

"Modern medical and dental equipment is needed to attract medical and dental personnel and to enable them to provide good medical care.

"Recommendation: Health centers and hospitals can be brought to rural areas under the Federal Hospital Survey and Conctruction Act and local communities can otherwise help equip a doctor's or dentist's office. Action along these lines should be taken in areas where the need exists."

2. This resolution was reaffirmed at the last (1948) annual session of the National Grange.

3. Rural areas suffer more than other areas from the scarcity of medical personnel. This is a fact supported by experiences of farm people and by statistical studies. In "Better Health for Rural America" published in 1945 by the United States Department of Agriculture, we find the statement that in the 1,000 most rural counties, there was only one doctor for every 1,700 people while in the big city areas there was one doctor to every 650 people. In addition we know, and statistics show, that the country doctors tend to be well along in years. In rural areas, there was only one dentist to every 4,200 people while in the cities there was a dentist for every 1,400 people. In many rural hospitals, there is not even one graduate nurse.

4. With the recent spell of agricultural prosperity, the income of farm people in many areas has come up close to urban income, and farm people are demanding more medical attention. To meet this need adequately, more well-trained doctors are needed. Last year we ran a small note in our Deputy Newsletter saying that a young doctor had written to us concerning a place to practice. We received many prompt inquiries telling of the need for a doctor in the community. Usually

the situation is that the old doctor had made a good income but had died or retired.

5. There are many young farm boys and girls who are very intelligent, of good character, and of pleasing personality who would like to study to become doctors, dentists, nurses, and so on, but who cannot afford the cost of schooling. We, as a farm organization, would like to see farm boys and girls have a chance to develop their talents to the highest use; and, also, we know that after these farm boys and girls are trained, many of them would return to rural communities and make a real contribution to the health and happiness of the rural people.

6. You will note that the resolutions relating to medical personnel adopted by the National Grange are rather modest when compared with the plan of scholarships and subsidy contemplated by title I of H. R. 4312 and H. R. 4313. Our resolutions say nothing concerning Federal action, and for the most part, our resolutions contemplated State and local action and private action. However, the National Grange has favored Federal aid for primary and secondary education and such Federal aid as has been given vocational agricultural training in high schools, and such Federal aid as the land grant colleges have received.

7. We are not in a position to evaluate the need for large-scale subsidization of medical schools. However, it may well be, we realize, that in the States with limited resources, the need for Federal aid to expand medical-school facilities may be as great as the need for Federal aid to primary and secondary schools. In general, the Grange has shown most interest in the use of scholarships as a way of increasing the number of medical, dental, and nursing school graduates. This is not only because of the fact that only a few rural boys and girls can afford to go to medical school, but also because it seems to us to offer a good way of maintaining and securing the best type of individual for the practice of medicine.

8. The Grange believes it is very proper for the citizenry to take what action it deems proper to increase the number of doctors. If it were not for our State-supported medical schools, the number of doctors would quite certainly be smaller than it is today, and the fee-for-service schedule would quite certainly be higher. From the standpoint of the people, it is probably good economy to increase the number of doctors even though enlarged medical schools and scholarships would cost money. The need for more doctors is so great that it is quite certain that without a stepped-up medical school program, medical services needs would not be met, and the result could easily be an increase in the fee-for-service schedule. This would certainly discourage people from getting the medical attention their health requires.

9. The Grange wants to maintain high-quality medical care and for this reason would oppose any lowering of standards in order to graduate more doctors. With the use of scholarship grants to well-qualified students, we are confident that the present standards can be maintained or even raised at the same time that we graduate more doctors.

10. While the Grange favors Federal aid for schools, it strongly opposes Federal control and would reject Federal aid if it meant Federal control. In this connection, we are glad to find that section 382 specifically prohibits any Federal control of medical education.

Mr. Priest. The committee will stand adjourned until 10 o'clock, June 16, at which time hearings will begin on title II.

(Whereupon, at 1:05 p. m., the committee recessed until 10 a. m. Thursday, June 16, 1949.)

#25b

NATIONAL HEALTH PLAN

THURSDAY, JUNE 16, 1949

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE OF THE COMMITTEE ON
INTERSTATE AND FOREIGN COMMERCE,
Washington, D. C.

The subcommittee met at 10 a. m., in room 1334, New House Office Building, pursuant to adjournment, Hon. J. Percy Priest (chairman of the subcommittee presiding.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills)—National Health, with respect to title II—Medical Research.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills)—National Health.

H. R. 3943, by Mr. Priest—To amend the Public Health Service Act to support research and training in rheumatism and arthritis, multiple sclerosis, cerebral palsy, and epilepsy, and other diseases, and for other purposes (omnibus medical-research bill).

Blindness and eye diseases: H. R. 5046, by Mr. Biemiller—To amend the Public Health Service Act to support research and training in blindness and eye diseases, and to aid the States in the development of community programs for the control of blindness, eye diseases, and for other purposes.

Mr. PRIEST. The committee will come to order. We are continuing hearings this morning on the bill H. R. 4312 and H. R. 4313, dealing in a general way with title II of those over-all bills, and H. R. 4918, the title that deals with medical research, and we also have H. R. 3943 and H. R. 5046 for general statements today.

Our first witness on title II and related bills, on medical research, will be the Assistant Surgeon General, Dr. Dyer.

STATEMENT OF DR. ROLLA E. DYER, DIRECTOR, NATIONAL INSTITUTES OF HEALTH, PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY, WASHINGTON, D. C.

Dr. DYER. Mr. Chairman and members of the committee, I appreciate very much this opportunity to appear, on behalf of the Federal Security Agency, to express our views on a group of bills which relate to the development and expansion of our medical-research program, both public and private. It has been my privilege, as Director of the National Institutes of Health for the past 7 years, to witness, and to participate in, a great upsurge of popular interest in medical research. It has been particularly gratifying to me—as a research worker in the Public Health Service—that this popular interest has been so accurately and so effectively translated into national legislation. Members of this committee, both individually and collectively, have played a leading role in this legislative advance on the medical-research front, and I should like to take this opportunity to express both my personal and my official appreciation for this wise and sympathetic leadership.

That popular and congressional interest in medical research is still on the increase is made abundantly clear by the large number of research bills under consideration by your committee during these present hearings. Fortunately, for purposes of general appraisal, most of these bills can be divided into two major groups. In the first group are H. R. 3943 and title II of both H. R. 4312 and H. R. 4313, which are identical bills. These bills, to which my statement is particularly addressed, would authorize the Surgeon General to establish one or more research institutes and to take certain other steps designed to expand or improve the program of the Service in the field of research generally. The second group, to which I shall make certain comparative references, consists of a number of bills which propose specific institutes and programs relating to a single disease or disease category—such as multiple sclerosis, cerebral palsy, epilepsy, rheumatism and arthritis, or blindness.

The major question involved in choosing between these two approaches is whether medical research will be promoted most effectively through fixing administrative structure for medical research by law or through allowing this framework to be determined administratively in the light of changing problems and developments.

We in the Federal Security Agency believe that medical research will be most productive if administrative arrangements for expanded research in the Public Health Service are left flexible, rather than set by law. Our objection to the establishment of additional categorical institutes by law does not mean that we are opposed to expansion of research in the diseases for which special statutory institutes are being proposed—rheumatism and arthritis, multiple sclerosis, cerebral palsy, epilepsy, and blindness. On the contrary, we believe a substantial expansion of research in each of these fields would be highly desirable. Nor does our objection to the statutory establishment of additional institutes mean that we are opposed to additional institutes as such. It simply means that we believe any additions should be made in such a manner as to contribute most to efficiency and economy of administration and to the productivity of research.

A brief review of the existing pattern of medical-research institutes in the Public Health Service may be helpful in providing a background for evaluating these two alternative approaches.

The National Cancer Institute was established by law in 1937 as the administrative mechanism for a broad attack on cancer, including grants to medical schools and universities for research on cancer, cancer research in the laboratories of the Public Health Service, grants for construction of cancer-research facilities and for teaching of cancer and a cancer-control program.

In 1946, the National Institute of Mental Health was established, and in 1948 the National Heart Institute and the National Institute of Dental Research were set up. Their functions closely parallel those of the National Cancer Institute.

In each of these institutes there has been established by law an advisory group—the National Advisory Cancer Council, the National

Advisory Mental Health Council, the National Advisory Heart Council, and the National Advisory Dental Research Council. The advice rendered by these bodies in special fields is supplemented by the general counsel of the National Advisory Health Council.

In addition to these four institutes created by law to deal with specific categories of disease, we have established two basic research institutes by administrative action: the Institute of Microbiology and the Institute of Experimental Biology and Medicine. These organizations deal not with a single disease, or group of diseases, but with basic problems of medicine and biology.

These six institutes are grouped together in the major research organization of the Public Health Service: the National Institutes of Health.

Enactment of the several bills proposing new statutory institutes now before this committee would increase to 11 the separate research organizations within the National Institutes of Health, and to 10 the number of national advisory councils on medical research and related matters. It seems reasonable to assume that enactment of any of these bills would be followed by proposals for still more institutes in the near future.

Our objections to the bills proposing new statutory institutes have been presented in our reports to your committee. I do not feel it necessary to review them in detail. I would prefer, rather, to outline briefly why we prefer the flexible approach embodied in H. R. 3943 and title II of H. R. 4312 and H. R. 4313 to the enactment of additional statutory institutes.

Areas of emphasis in medical research shift rapidly and unpredictably. Fields of investigation may lie fallow for years, and then expand rapidly as a basic lead is explored. As an example of that, I might remind the committee of a hearing that was held in this room last Monday morning on the development of compound E for the treatment of arthritis and ACTH for the same treatment. The emergence of antibiotics as a major weapon in the fight against disease is a case in point. Within the past month, investigations at the Mayo Clinic, building upon a basic structure of knowledge relating to the functioning of glands, have been reported, showing that a substance called compound E, extracted from ox bile, has in preliminary tests proved to be quite effective in treatment of arthritis. The full potentialities of this discovery, possible limitations upon its usefulness, possible areas of use as yet undiscovered and similar matters, must be uncovered by a great deal of additional research.

Research effort—funds, facilities, and manpower—must be readily shifted in response to such scientific developments. This flexibility is maximized if the structure for research can be adjusted by administrative action.

To insure the most effective distribution of research funds, the administrative organization established to deal with specific diseases must be carefully adjusted to the state of knowledge bearing upon the disease and to the nature and volume of research being conducted on the disease by governmental and private laboratories. For example, if a clear and authoritative definition of areas of research that appear potentially most productive is the major problem, a study by a national advisory commission might be the logical first step. If fields of research have been clearly identified and work is in progress in existing institutes, the logical way to expand research in a specific disease might well be to expand the functions of existing institutes. Under other circumstances, the establishment of an additional institute by administrative action might be clearly indicated.

This sort of adjustment of resources and organizational structure to changing needs, which is authorized by H. R. 3943 and title II of H. R. 4312 and H. R. 4313, is, in our opinion, preferable to the establishment of additional medical-reseach institutes by law.

We do, however, suggest one technical amendment to H. R. 3943 and to title II of H. R. 4312 and title II of H. R. 4313. The Surgeon General should be empowered to name a national advisory council for a specific disease before, as well as after, he establishes an institute. Under this authority, the Surgeon General could secure the advice of a formally established group both on the content of proposed research and on the most effective administrative structure without taking the ultimate step of setting up an institute. I should also note that both H. R. 4312 and H. R. 4313 would be strengthened and improved by the inclusion of provisions authorizing the Surgeon General to expand and rename existing institutes or councils as an alternative to the establishment of additional units. H. R. 3943 already contains such provisions, which we believe to be highly desirable.

With these changes, enactment of H. R. 3943, title II of H. R. 4312, or title II of H. R. 4313 would round out the research authority of the Public Health Service in a manner that will contribute substantially to the productivity of research.

In conclusion, I should like to comment on the provisions of H. R. 3943, H. R. 4312, and H. R. 4313 which would authorize the payment of salaries between $10,000 and $15,000 to not more than 30 scientific and professional employees of the Public Health Service engaged in research and development.

The need to pay higher salaries to a limited number of research scientists has been recognized by Congress. The armed forces have been authorized to pay salaries ranging from $10,000 to $15,000 to a limited number of scientists engaged in the research and development program of the Military Establishment. During this session of Congress, committees of both the Senate and the House have approved a measure which would grant comparable authority to the Nation's aeronautical-research organization: the National Advisory Committee for Aeronautics.

Application to the Public Health Service of the established principle that more adequate salaries must be paid to outstanding scientists is critically important to the success of our medical-research efforts.

The emergency of providing for payment of more attractive salaries to outstanding investigators is borne out by recent experience. Within the last few months two key scientists have left the Public Health Service because of financial pressure. One was a brilliant radiologist who was being groomed to assume extensive responsibilities in connection with the radiological program of the clinical center of the National Institutes of Health now being erected in Bethesda, Md. He is now the head of the department of radiology of one of the largest western universities. His income is more than double the highest salary that we could offer. Another scientist, a brilliant psychiatrist employed by the National Institute of Mental Health, has resigned to work at a clinic at a salary higher than the Public Health Service can pay.

It is a rare month when at least one key scientist of the Public Health Service is not offered a position in a university, private foundation, or industry at a salary which would double or triple his income. It is a tribute to the devotion of these men to their work, to their competence, and to the vitality of the research program of the Public Health Service that they are willing to turn down positions that would ease their financial worries. As things now stand, however, we must expect a certain number of them to place the welfare of their families ahead of their professional and scientific preferences.

Since this was written, in the last few days, we have lost two additional men to industry.

The other side of the coin is recruitment of additional scientists of the highest competence. The scientific opportunities in the Public Health Service are so attractive that we can recruit a small number of men with the highest national scientific standing. For example, the chief scientist of one of the largest drug manufacturers in the country recently accepted employment at the National Institutes of Health at a salary less than one-third of that paid to him by industry. But, to make the shift financially bearable, his wife is working. As another example, we are attempting to secure the services of a nationally known psychiatrist for the National Institute of Mental Health. He is enthusiastic about the work which he would be doing with us, but he simply cannot afford the loss of income that would be involved.

We do not ask that the Public Health Service be allowed to match the salaries paid in the highest university and industrial-research posts. We are confident, and our experience confirms our confidence, that our research program offers such freedom, facilities, and congenial working atmosphere that the best men will sacrifice money to work with us. But we cannot ask them to jeopardize the basic financial security of their families.

These men are more than competent scientists. They are the source of ideas which others develop. They provide the intellectual spark, the flow of ideas, and the quick insight that are indispensable to a research organization.

Men of this caliber must be found and kept if, from the research building and equipment provided by Congress, are to come the leads that will eventually conquer those diseases that are claiming a rising toll in pain and death.

I am convinced that the investment of $150,000 per year—the maximum possible annual cost of this provision of the bill—will be repaid many times over in the form of increased productivity of research.

I should like to add, Mr. Chairman, that while this statement has not been cleared by the Bureau of the Budget, the Bureau has cleared our report on H. R. 3943, indicating their general approval of that bill and of the approach which it represents.

I should also like to note that, while my statement covers our position on most of the research bills under present consideration by your committee, there are several other bills scheduled for hearing on June 23 and 24, to which my remarks are not applicable. These include House Joint Resolution 7, dealing with research in Alaska; House Concurrent Resolution 29, relating to research on family aspects of chronic illness; H. R. 4030, dealing with the leprosy situation, and H. R. 4840, proposing a national survey of sickness. The views of the Federal Security Agency on these measures have been fully covered in the Administrator's reports to your committee. If you should so desire, however, we would be very happy to have one or more representatives of the Agency present during the hearings on these bills for the purpose of answering any questions which might arise.

Thank you, Mr. Chairman.

Mr. PRIEST. Dr. Dyer, we thank you for your statement.

Aside from the need, and as I see it, it is a need of the authority to employ a limited number of scientists at salaries ranging from $10,000 to $15,000 a year, will the situation be somewhat improved in the Public Health Service by the passage of the uniform services pay bill that passed the House yesterday, that included the Public Health Service?

Dr. DYER. It will be helpful to some extent, Mr. Priest, but—and I do not know too well the provisions of that bill—but the salaries that we would pay under that bill would have to bring them in at the top bracket we can under the law which would only be about $11,000. My figures may be off a little bit, but that roughly is what it is.

Most of these scientists we want to bring in will be under the civil service, that class of employees.

Mr. PRIEST. Yes. My thought was, and my understanding, that it would perhaps benefit those in the grade of medical officer and enable the Public Health Service to retain the services of medical officers that it now is losing so frequently, and that it would be some help in that respect.

Dr. DYER. Well, it will help in some respects so far as the medical officers are concerned. It will not be of much assistance so far as scientists are concerned. Most of them come under civil service appointments. A large share of them at the present time are not medical officers, but are Ph. D.'s in biochemistry, or biophysics, and similar allied skills.

Mr. PRIEST. One other question before I pass the questioning on, Doctor.

I agree with the position taken by the Public Health Service, and I think that a great many of us do at least in theory. I feel that the establishment of special institutes is most desirable but I think there should be some flexibility. On the other hand, a great many persons who are particularly interested in these institutes, have the feeling—and they present their views to the committee—that without emphasis, statutory emphasis, on some particular disease, that we are not likely to get the attention insofar as research is concerned on that disease as we would get if it were specifically directed by statute.

I wonder if you have any comments on that controversy, which undoubtedly has come to your attention.

Dr. DYER. Yes, sir; I have heard it discussed a great many times. But, Mr. Priest, I think this bill here gives the Surgeon General administrative authority to do it; I think that covers that point, particularly in view of the fact it empowers him to set up particular councils for specific diseases.

Might I go on just a moment?

Mr. PRIEST. Yes.

Dr. DYER. It is extraordinarily difficult in research to see ahead. We have plans for the future; we know the problems, and we know the diseases that should be covered; but we do not know what is going to be discovered a year from now, what techniques may be, what new thing is going to be developed within the next year that may change the direction of research. The most extraordinary example of that that I have seen in 30 years of experience, is what I referred to a while ago as compound E and ACTH in the treatment of arthritis.

Now, that change opens up a broad field of medical research and a new attack on the general degenerative diseases and even mental illnesses that we did not have before.

The flexibility that is provided for in this bill would enable us in many ways not only to cover that point, but also things that may develop in the coming years that we do not know anything about now.

Mr. PRIEST. I quite agree with your theory, Doctor, and I think the practice might well be worked out.

One further question: In the bill, H. R. 3943 and in title II of the bills 4312 and 4313 with reference to institutes, the establishment of institutes, we have a parenthetical line that reads, "including rheumatism, arthritis, multiple sclerosis, cerebral palsy, and epilepsy." And my question is whether the flexibility otherwise provided in this bill would in any way be endangered if in that sentence we included for example, blindness, or we included two or three other diseases, in a sentence of that sort.

Dr. DYER. No; that is perfectly all right. In fact, I had thought that blindness was already included in that.

Mr. PRIEST. In the bill it was not.

Mr. Biemiller, however, has a bill for blindness; but in the omnibus bill and in 3943, blindness is not included.

Dr. DYER. As a matter of fact, Mr. Priest, I think it would be a good change.

Mr. PRIEST. Thank you, sir. Mr. Stanley, do you have any questions?

Mr. STANLEY. No; I do not, Mr. Chairman.

Mr. PRIEST. Mr. O'Hara?

Mr. O'HARA. Yes. Doctor, of course, we are not going to solve the problems of these various diseases by simply passing laws, are we?

Dr. DYER. No.

Mr. O'HARA. And we have passed many bills, acted on them before this committee, and many have been reported out, making authorizations of money for treatment of various types of diseases. We have many bills before us now which have not been acted upon.

Do you feel that there is gross duplication in the many departments of Government and the many private or quasi-public studies and investigations, and directives together with what we are asked to legislate in some of these bills? Do you feel that it is worth while or that we are overlooking something, so to speak, in some of these fields?

Dr. DYER. I think it is worth while, Mr. O'Hara.

One thing that medical research demands and must have is freedom of thought. I, myself, would be much worried and would definitely dislike to see all of the money that goes into medical research go into one pocket and be taken out of one pocket; but there has been a very happy thing that has happened in the past few years which pleases me personally, and the Public Health Service immensely, and that is the fact that the efforts of the Public Health Service, as a result of enabling legislation from the Congress in the study of heart disease, has increased public interest and private contributions to the various associations. That has also happened in the field of cancer.

Duplication, as used in research, is rather a difficult word to define. In applied research, after basic principles have been found out and are to be carried to the field, there might be, to some extent, some duplication there. It is possible. I do not know of any instance of it. But, in basic research, the word "duplication" does not belong at all, for the simple reason that you do not duplicate men's minds and these investigators are developing original thought and original ideas.

May I put it this way: If the problem was important enough, I would not object at all to having one man working at one end of a floor in one of our laboratories on poliomyelitis, we will say, or arthritis and rheumatism, and another man working down on the other end of the hall, on the same subject, and maybe they might not be on speaking terms.

Now, that is a rather definite way of putting it, but the point I am trying to make is that so far as research is concerned, you cannot duplicate men's minds and men's ideas.

Mr. O'Hara. Of course, you cannot achieve results by passing a law or appropriating huge sums of money.

Dr. Dyer. That is right.

Mr. O'Hara. For example, how long has the medical profession been working on cancer alone? Still, they have not been able to find an approach to the answer.

Dr. Dyer. That is quite true, Mr. O'Hara. The furnishing of huge sums of money will not answer the question, but without some money to do the work we cannot do it, either.

Let me talk just about cancer. We have got one of the most interesting things I have seen right out at the National Cancer Institute, and this work started something like, it must have been, 15 years ago. A man is trying to grow a cell and he has developed a method of growing human cells on media. He has now got a gland that is growing that he started, with pituitary gland, and he has got it growing and it is about 8 by 4 inches in size.

Now, by applying radiology to that, by applying other things to that, they may be able to turn that gland into cancer or maybe something that gland will produce, this artificial gland that is growing there may lead to solving one of the problems of cancer—and there are very many of them.

We do not know where these basic ideas and basic results we get are going to end.

I am afraid I am talking too much, Mr. Chairman; but here is the sort of thing we have—the man that first did the developmental work on the electromicroscope quite a number of years ago did not know that Dr. Wykoff was going to show the action of viruses on cells by that means.

In other words, the man 15 years ago did not know that he was doing a very important piece of medical research.

Alexander Flemming, when he saw a bare place on a Petri's dish in 1929 one morning in the laboratory, did not know that he had made one of the most important medical discoveries of this era—in other words, penicillin.

Without money we cannot do it.

Mr. O'Hara. Many scientists and medical men do not want to work for the Government. The answer of salary to me is not the whole answer.

Dr. Dyer. Well, the scientist—I think this is especially true for all scientists—what he wants out of life, and all he expects is a salary sufficient so that his wife does not worry him about the cost of pork chops when he goes home at night, and so that he can look forward to educating his children and look forward to not being dependent upon some of his children or someone else after he has retired. Now, that is the main thing; those are the main things that a scientist, or even most of us, want, so far as that goes, Mr. O'Hara, but the present pay does not assure these things.

We are rather proud of the fact that many very able scientists are glad to work at the National Institutes of Health even at a financial sacrifice. I think the main reason for that is that we insist on absolute mental freedom in the prosecution of ideas there. The salary is not the whole thing. You are exactly right.

Mr. O'Hara. That is all, Mr. Chairman.

Mr. Biemiller. Mr. Chairman.

Mr. Priest. Mr. Biemiller.

Mr. Biemiller. Doctor, to come back a moment to a line of thought Mr. Priest opened up, I think there is also a third suggestion that has been thrown out by some interested in the bills.

As I see it—I would like your comment on it—it might be desirable to take the various diseases, such as arthritis, cerebral palsy, epilepsy, and other neurological problems and put them in an over-all neurological institute rather than setting up one for each of these diseases.

Dr. Dyer. Yes; I think that is right, Mr. Biemiller. That thought has occurred to some of us in discussing this.

We have a National Institute for Mental Health. There is no reason at all why that should not be a National Neurological and Mental Health Institute. As a matter of fact, I think mental health should be expanded to include neurological conditions under the law.

Mr. Biemiller. Could that conceivably make for some economy in the over-all administrative expenses?

Dr. Dyer. Yes; very definitely. You see, when we establish an institute we have to have a certain administrative structure set-up and if that is all gathered together and a lot of those administrative things can be handled by a central organization, then there is definite economy, instead of establishing a neurological institute, an institute for the study of multiple sclerosis, and so forth.

If we could have the authority and the title changed of the National Institute of Mental Health to National Neurological and Mental Health Institute, or something of that sort, it would be a definite economy and administratively would be much easier to handle.

Mr. Biemiller. At the same time, do you think that it would affect any of the scientific work?

Dr. Dyer. No.

Mr. Biemiller. I am just thinking, as I assume all of the members of the committee are, about some of the things that might to be done to effect economies and efficiency if we authorize additional research institutes.

Now, do you think that the proposed wording would give you power under the omnibus research bill of that legislation were reported out?

Dr. Dyer. I think it does; yes.

May I ask Mr. Woolpert to answer that?

STATEMENT OF ELTON WOOLPERT, ASSISTANT TO THE SURGEON GENERAL

Mr. Woolpert. Title II does not contain quite as broad provisions on this flexibility feature as does H. R. 3943.

Title II would authorize the Surgeon General, with the approval of the Administrator, to establish one or more additional institutes and to abolish them when they had served their purposes. It does not in its present form do what H. R. 3943 does; namely, authorize the Surgeon General, in lieu of establishing additional institutes or additional councils, to expand and rename an existing institute or council.

So that to that extent, H. R. 3943 provides what we believe to be an additional and very desirable measure of flexibility. Title II could readily be amended to incorporate that provision.

Mr. Biemiller. I think that is the intent, as I read it.

Mr. Woolpert. Obviously, that is the intent, but there is the omission of that "in lieu" section in two particular places in the bill.

Mr. Biemiller. That is all.

Mr. Bennett. Mr. Chairman.

Mr. Priest. Mr. Bennett.

Mr. Bennett. Is it your idea, Doctor, that rather than naming these various types of diseases, in connection with which research is to be made, we ought to simply authorize the Surgeon General to make whatever kind of research as to these various diseases, that he sees fit, rather than setting up separate organizations for each title?

Dr. Dyer. If it is left to administrative action, we might be able to adjust more readily to further future developments.

Mr. Bennett. You are opposed, then, to this bill, H. R. 3943, as it stands?

Dr. Dyer. No; no; not to H. R. 3943. No; we are very much in favor of that.

Mr. Bennett. Is there anything else that ought to be included? Would it solve the problem, as you see it, to give the Surgeon General the right, or give him the authority to carry on such types of research in connection with the various diseases as he sees fit?

Dr. Dyer. Yes, sir.

Mr. Bennett. And not limit it to these mentioned?

Dr. Dyer. That is exactly right. He could establish an institute on peptic ulcer.

Mr. Bennett. Why would you desire to name any particular disease?

Dr. Dyer. Well, I think it is desirable from the point of view of the general public that they need to know that the Congress is interested in these diseases, for you to put stress on them, because some of them are really very horrible diseases.

I think so far as public relations are concerned, they should be named like they are here.

Mr. Bennett. Well, if you pass the bill just giving the Surgeon General the right to carry on research in any diseases that he thinks are important enough to warrant spending the money for research on, and let him use his discretion, would that be satisfactory? Or does he have that authority now?

Dr. Dyer. They have the authority for broad research in medical fields; yes. We can do research on arthritis and multiple sclerosis and other diseases, but emuneration in the bill serves to focus the public's attention on certain problems.

I am not talking about the appropriations bill or the money we get from Congress. Congress has always been very friendly toward medical research. But it also serves to focus public attention and increases, surely, in my mind, the public contributions and their interest in some of these diseases. I think that is very important, a very important part.

Mr. Bennett. It seems to me the minute you start naming these various diseases, and then omit some, that that gives rise to the necessity for further legislation for the study of other diseases as they come up. I should think that you would rather have, as I understood your testimony here, that you would rather have the Surgeon General given authority to go ahead and carry on research in such diseases as he thought research was advisable in and then if there is public interest in any particular disease, I am sure it would be called to his attention, and if worth while, Members of Congress could say to the Surgeon General that he has authority to do it and ask him why he was not doing it; find out why.

Dr. Dyer. Well, Mr. Bennett, I agree with what you are saying, but that is something that Congress has decided.

Mr. Bennett. I am asking what you think as an expert.

Dr. Dyer. The Surgeon General, at the present time, as I understand, has authority for a very wide field of medical research, provided funds are available.

The real reason, as I see it for the introduction of these bills expanding separate institutes is to focus, as I said, the public attention on those.

Mr. Bennett. Yes. The minute you leave one out, then you are going to have to go through the procedure all over again, are you not?

Dr. Dyer. That is quite true; but if we establish an institute for multiple sclerosis and a separate institute for arthritis and a separate for epilepsy, you see, we can look forward, and I think the Congress can look forward next year to establishing one for peptic ulcer and so on and on. But this would forestall that sort of thing. I do not mean to be facetious about that.

Mr. Bennett. That is just my point; why name any of them?

Dr. Dyer. Mr. Woolpert has one point that he wants to clarify.

Mr. Woolpert. It is true that the Surgeon General now has very broad authority for basic research in all diseases. I would like to point out, however, that there are certain supplementary items of authority which he now has for certain diseases only, which H. R. 3943 would extend across the board.

For example, under the Heart Act, which was enacted last year, authority was given for traineeships, for specialized teaching grants, and for construction grants for research facilities. We also have that same authority in connection with cancer. We do not have it in these other fields. This bill would fill out the broad authority in these three particular respects.

I just wanted to add that to clarify the record. We do not have those several authorities in all those fields at the present time.

Mr. BENNETT. Would not one bill answer this whole thing?

Mr. WOOLPERT. That is our basic thinking.

Mr. BENNETT. Is 3943 that bill?

Mr. WOOLPERT. That now comes the closest to it. We did suggest one small amendment. That is to authorize the Surgeon General to establish a council without necessarily establishing at the same time an institute. But apart from that H. R. 3943—and some additional changes to title II—would provide that authority quite adequately.

Dr. DYER. I want to add to what Mr. Woolpert said, H. R. 3943 settles the problem so far as we can see it with this minor change that we are suggesting.

Mr. BENNETT. I was just thinking that we might do it, so as to settle it for good.

Dr. DYER. That is what we think H. R. 3943 does.

Mr. BENNETT. You do not think we would have to have any further bills or further diseases?

Dr. DYER. I think we have got all of the authority there and that all we will have to do in the future would be to amend H. R. 3943 by just inserting one more word in that.

Mr. BENNETT. That is all.

Mr. O'HARA. Mr. Chairman.

Mr. PRIEST. Mr. O'Hara.

Mr. O'HARA. What difficulty would you have with the Appropriations Committee? Would they insist upon certain allocations or earmarking funds for certain research?

Dr. DYER. No. As a general thing, our funds, when justified before the Appropriations Committee are quite fluid.

We have to make, of course, our estimates 14 months in advance and they all recognize that, so when the appropriation is made, with a few restrictions, they are quite fluid, and if a new idea develops we can take a hold of it without waiting for authorization. We have very good authority and the Appropriations Committees, both in the House and the Senate, and the Members of the Congress, have always been very friendly toward medical research.

Mr. PRIEST. Will the gentleman yield there?

Mr. O'HARA. Yes.

Mr. PRIEST. For example, your schedules on your budget and your appropriation for the next fiscal year following the incoming fiscal year are already under consideration.

Dr. DYER. Oh, yes, sir.

Mr. PRIEST. And have been for some time?

Dr. DYER. The 1950 budget today, I think, is before the conferees, and, of course, we are already beginning to make up our budget for 1951.

It is very difficult, in research, to see 14 months in advance.

Mr. PRIEST. And if in that 14 months that might elapse, a process for synthesizing compound E, for instance, is completely developed and made available to the public for use and your views as to having an institute set up for arthritis or rheumatism might entirely change when the time came for the appropriations hearings and you were requested to furnish information for funds in that field.

Dr. DYER. That is right. Our appropriation language is always and has always in the past been flexible enough so that we can take care of that.

Mr. PRIEST. Are there any further questions?

Dr. Dyer, we certainly appreciate your appearance before the committee.

Dr. DYER. Thank you very much, Mr. Chairman.

Mr. PRIEST. Our next witness is Dr. Austin Smith, of Chicago, representing the American Medical Association.

Dr. Smith. you may proceed.

STATEMENT OF AUSTIN SMITH, M. D., DIRECTOR, DIVISION OF THERAPY AND RESEARCH, AND SECRETARY, COUNCIL ON PHARMACY AND CHEMISTRY, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

Dr. SMITH. Mr. Chairman and members of the committee, I have prepared a brief written statement which may be dispensed with if I have your permission and, instead, I would like to introduce my remarks by referring to two paragraphs in this brief statement and read these statements.

Mr. PRIEST. You desire to include the entire statement in the record?

Dr. SMITH. If I may.

Mr. PRIEST. Without objection, the entire statement will be included, and you may proceed as you desire.

(The statement referred to is as follows:)

STATEMENT BY AUSTIN SMITH, M. D., DIRECTOR, DIVISION OF THERAPY AND RESEARCH, AND SECRETARY, COUNCIL ON PHARMACY AND CHEMISTRY, AMERICAN MEDICAL ASSOCIATION

The board of trustees of the American Medical Association has requested Dr. Andrew C. Ivy and me to appear before your committee as representatives of the association at hearings pertaining to medical research. Unfortunately, Dr. Ivy cannot be present because of need for his presence in Springfield, Ill.

The American Medical Association has supported medical research by issuing grants to research workers, initiating research projects, arranging conferences for the exchange of information and ideas concerning significant research problems, establishing offices for the evaluation and advancement of therapeutic technics, and in other ways. While there are available many reports on the activities of the association in research fields, summaries of some of its interests may be found in A History of the American Medical Association (W. B. Saunders Company, 1947) and Some Research Interests of the American Medical Association, by Austin Smith (Food Drug Cosmetic Law Quarterly, June 1948, p. 216). I beg the indulgence of the committee for emphasizing what may be obvious, but since my work is intimately concerned with these phases of association affairs it seems advisable to direct attention to the relation existing between medical research and the American Medical Association; it will serve to stress that this organization always has been and is in favor of measures that will lessen the suffering of the people in this Nation and throughout the world.

To achieve consistently worth-while medical advances it is necessary to execute plans for them in an orderly manner. Research does not stem solely from an availability of abundant funds or from accidental discoveries. It also depends on painstaking searching, close collaboration between mutually interested parties, farsighted vision of researchers and executives, and appreciation of the time and effort that usually is required and of the value of the so-called fundamental or basic research on which practical applications are founded. Thus, it is not possible to determine the cause of, and cure for, a given disease simply by appropriating funds marked for that specific purpose. One never knows when seemingly unrelated research efforts may elicit the information necessary to eradicate a previously uncontrollable disease. Such research is not always productive in the usual sense, but it provides training for the younger men that are needed especially at this time. Such research is not wasted; it is the proving ground for future leaders.

Immeasurable advances already have been made on comparatively slender financial resources. Such sums can and should be augmented, but to be fully effective they should not be allocated to specific diseases such as would occur if separate bills were enacted for, say, multiple sclerosis, cerebral palsy, epilepsy, and other diseases. Nor should they be made available with the thoughts that fruitful research can be bought and that adequate money will prevent disappointing reverses in research. Money from Federal sources could be allocated through a national science foundation and the study sections of the United States Public Health Service. Such allocation of money has been supported previously by representatives of the American Medical Association.

Medical research has advanced so far and so rapidly that it, not disease, has posed the problems that exist today. If such advances had not been made there would not exist the present need for funds to support research workers as they explore the various avenues that have been opened. Funds provided by Federal taxation can be allocated with advantage when it is evident that research is not adequately supported by funds from other sources, but they should be offered to support research that is suggested by the institutions seeking support, i. e., the institutions, except in rare instances, should take the initiative. The money should be fluid and not specifically "tagged" for certain diseases; it should not be made available so freely that it exceeds the demands of existing or available personnel and facilities, nor should it encourage excessive expansion. Funds should be provided to stimulate research in fields in which progress is not commensurate with their importance to public-health programs; and they should be administered with the thought that the institutions and individuals needing such support must have complete freedom in developing research programs. Whether the funds are for research, research construction, grants-in-aid, or fellowships, their use and disbursement should be guided by the same principles.

Dr. Smith. These two paragraphs may serve as a basis for further discussion [reading]:

Immeasurable advances already have been made on comparatively slender financial resources. Such sums can and should be augmented, but to be fully effective they should not be allocated to specific diseases such as would occur if separate bills were enacted for, say, multiple sclerosis, cerebral palsy, epilepsy, and other diseases. Nor should they be made available with the thoughts that fruitful research can be bought and that adequate money will prevent disappointing reverses in research. Money from Federal sources could be allocated through a national science foundation and the study sections of the United States Public Health Service. Such allocation of money has been supported previously by representatives of the American Medical Association.

Medical research has advanced so far and so rapidly that it, not disease, has posed the problems that exist today. If such advances had not been made there would not exist the present need for funds to support research workers as they explore the various avenues that have been opened. Funds provided by Federal taxation can be allocated with advantage when it is evident that research is not adequately supported by funds from other sources, but they should be offered to support research that is suggested by the institutions seeking support, that is, the institutions, except in rare instances, should take the initiative. The money should be fluid and not specifically "tagged" for certain diseases; it should not be made available so freely that it exceeds the demands of existing or available personnel and facilities, nor should it encourage excessive expansion. Funds should be provided to stimulate research in fields in which progress is not commensurate with their importance to public-health programs; and they should be administered with the thought that the institutions and individuals needing such support must have complete freedom in developing research programs. Whether the funds are for research, research construction, grants-in-aid, or fellowships, their use and disbursement should be guided by the same principles.

Mr. Chairman, I believe it would save your time if I could let that consist of my statement and put myself before you for questioning so that if there is any information that I can provide in the fields in which I have any special interest, I might be helpful to your committee.

Mr. PRIEST. Thank you, Doctor, and we appreciate that spirit of cooperation with the committee.

Have you had an opportunity to examine specifically the provisions of H. R. 3943, or title II of the omnibus bills?

Dr. SMITH. I am familiar in a general way with it. I am not familiar with the details. I make no pretense of being versed on legal procedure.

Mr. PRIEST. Well, in general, then, may I ask: Do you approve of the approach and the general provisions of H. R. 3943 for medical research?

Dr. SMITH. In general; yes, sir.

Mr. PRIEST. Are there some other questions? Mr. Stanley?

Mr. STANLEY. I have no questions.

Mr. PRIEST. Mr. O'Hara?

Mr. O'HARA. Doctor, you speak of the Scientific Foundation bill which this subcommittee reported out Monday to the full committee, and I guess the full committee has reported it out also. Doctor, do you visualize any danger of overlapping upon these subjects of public health?

Dr. SMITH. Mr. Congressman, there is one thing that I believe needs emphasis today; that is the enthusiasm that seems to be generated or is being generated on the part of so many who feel there is need for medicine and drastic action. Perhaps that is inevitable. But, on the other hand, we also must recognize that there is a limit to the scientific personnel that we have at the moment; there is a limit to the speed with which we can train other scientists; and, under the circumstances, there is a limit to the practical application of the vision of these scientists.

I recognize the thoughts behind your question, and I do feel that there is a possibility that our enthusiasm may get the best of us and that too much money could be made available when there are not adequate facilities or personnel at the moment. However, if these problems were approached systematically and only after careful study, I feel that over the years, probably with proper advice from experts in the field, that danger would be kept to a minimum.

I recognize that is not a direct answer to your question, but it is something on which one cannot comment other than in general terms.

Mr. O'HARA. I appreciate that, Doctor. I appreciate it would require a general answer.

Dr. SMITH. That is why, Mr. Congressman, it is best, I believe, for individuals who are interested in research to seek the advice of experts in a variety of fields and who have a variety of interests in research fields, because when these thoughts are pooled, usually the action recommended is a reasonably conservative but progressive one.

Mr. O'HARA. Of course, in the development of scientific research, Doctor, there are so many fields that you find—at least I find myself running into two schools of thought: Those who, in their enthusiasm, think we should pass a law and should appropriate a lot of money, and those who immediately say that they do not want the dead hand of government on them. Then, as scientists, they say, "I do not want the Government telling me what to do."

And I think we probably will have to find some medium in between where perhaps there can be a direction, say, by the Surgeon General or by some private group in research along the lines we would develop and coordinate the various agencies that are working along the same scientific lines.

Dr. Smith. Mr. O'Hara, in the last paragraph which I read in my statement, I made reference to a thought that is in your words when I said that:

> Funds provided by Federal taxation can be allocated with advantage when it is evident that research is not adequately supported by funds from other sources.

I personally believe that funds made available through Federal taxation should be reserved for situations that cannot be resolved on a voluntary basis or by funds that are already available. There are several reasons for that belief. Most of them are obvious, but one important reason we cannot ignore is the interest that is generated by civic-minded groups when they take a personal interest in the solicitation and expenditure of funds. The majority of people who serve on voluntary committees probably take more interest in what these committees do, than if the committees were legally empowered by Government dicta to take certain stands. In the latter instance, we would tend to say, "Well, the committee can work out the problems," and we would lose that personal touch, and that personal interest. That may not be the most important reason for my quoted statement, but I believe it is one thing commonly overlooked in our discussions of the use of funds for research.

Mr. O'Hara. Thank you, Doctor.

Mr. Priest. Mr. Biemiller.

Mr. Biemiller. I have no questions.

Mr. Bennett. Mr. Chairman.

Mr. Priest. Mr. Bennett.

Mr. Bennett. Is it your view, Doctor, that expanding Federal research in the public-health department will, or might, have the effect of curtailing it in private groups, among private medical groups?

Dr. Smith. There is that possibility, if the funds are not allocated with considerable thought. Again——

Mr. Bennett. And let me——

Dr. Smith. Pardon me.

Mr. Bennett. What do you mean when you say in that statement you read to Mr. O'Hara, "that funds provided by Federal taxation can be allocated with advantage when it is evident that research is not adequately supported by funds from other sources"?

Do you have anything specifically in mind in that connection? You say that funds should be offered in support of research that is suggested by institutions seeking support?

Dr. Smith. That is right, Mr. Bennett. There is in the minds of some individuals the thought that money should be allocated to certain institutions or organizations, with almost the directive—at least the suggestion, that this money be used for certain purposes. This is wrong. The principle is wrong in practice, because many institutions to which money might be given are not necessarily equipped to do the type of research desired by the donors, whereas on the other hand, the ones who will seek the help, you will find, usually are qualified in the fields for which they want money. At least this has been the feeling of many individuals, particularly those in the scientific fields in which I work. They have discussed this problem with me, and believe that funds can be best used and interest best maintained, and overexpansion minimized, if the initiative is always taken by the interested group, the one who needs help, because they have the personnel to take care of the problem and they have the incentive to undertake proper investigations. The initiative should not be taken by the group that may just have the power of making funds available.

Mr. BENNETT. You mean that the Federal Government ought not to expand its research unless private scientists make the request that such work along specific lines that cannot be accomplished through private source——

Mr. SMITH (interposing). My belief is that funds should be made available for research but those funds should not be allocated except when specific request is made from the interested parties, whether it came from within the Government or outside of the Government, and that the requests should be supported by appropriate statements indicating the need for it.

If I may digress just a moment to offer as an example the way funds are allocated by the American Medical Association; there were two committees—there is now one bigger committee—interested in the issuance of grants—grants-in-aid—for research workers. The grants are modest and are intended to help the research workers solve their problems; not to maintain an entire project. These individuals submit their requests to the research committee with statements explaining the nature of their work, and the purposes that they have in mind when they make their requests. A somewhat similar situation exists for individuals who make application to the various study sections of the Public Health Service that recommends the issuance of grants for, of course, larger scale research efforts.

That approach, I believe, tends to keep to a minimum the promiscuous seeking of funds, and it presents, at the same time, a means whereby research workers who have a legitimate need for funds and help can seek the help that they request or need.

Mr. PRIEST. Will the gentleman yield?

Mr. BENNETT. I will yield.

Mr. PRIEST. If I understand your position, then, clearly, you feel that a grant-in-aid should not be made, for example, to Vanderbilt University Medical School to do research in cancer unless Vanderbilt was specifically equipped both from the standpoint of research workers and equipment and otherwise to do that particular research work?

Dr. SMITH. Equipped or can show that it will be properly equipped to make proper use of the funds.

I would like, however, to qualify that statement with one thought. Not infrequently it is necessary to train individuals and it is not unusual to find one institution becoming interested in a field in which it had not been interested previously. That does not mean that it cannot develop a legitimate interest, because it can very well, with proper personnel.

Mr. BENNETT. Well, in my mind, it is difficult for the average person or Member of Congress to determine just how much money ought to be provided for by the Government in these fields of research, particularly in a case like cancer, where there is a great public support, financial support, and private support for that particular program.

Do you think, for example, in that field, that the Federal Government needs to specifically provide money for research?

Dr. SMITH. Yes, I do, sir, in that field, because the field is so broad and we need so much knowledge that every contribution will be helpful as is evident from the outstanding research that is being done at the National Institutes of Health, the efforts of voluntary agencies such as the American Cancer Society which makes available large grants of money, and the work undertaken at many institutions throughout the country that are devoting time, personnel, and even funds. Cancer involves such a broad subject that we need every assistance that can be provided.

But that does not necessarily mean that we will want to see a mechanism set up whereby there will be unlimited funds, say 10 years from now, because the problem of cancer may well be solved 10 years from now.

Mr. BENNETT. Of course, Congress appropriates for that work from year to year.

Dr. SMITH. Yes, sir.

Mr. BENNETT. What about infantile paralysis; do you feel the same about that as you do about cancer, so far as Federal funds are concerned?

Dr. SMITH. I feel at the moment that there are sufficient funds available for the study of this disease with a few exceptions, for example, as Dr. Dyer pointed out a few moments ago, it is conceivable that within his organization, he would like one or more individuals working on certain basic phases of the problem. That should be supported.

But, to enact a bill which would call for unlimited or semiunlimited support of the problem, I think, is unnecessary at this time. And that is true for many other diseases.

I made a survey before I left Chicago, of the cases that exist in this country of epilepsy and leprosy and cancer and so on, and have tried to prorate, so to speak, the problem that exists today, with the need for funds. I did not include how much money is needed at this particular time, but I cannot help but warn—and this is not intended to be pessimistic or antagonistic to any proposal that needs to be made—against the unnecessary expansion of facilities that may exist at the moment if these facilities are sufficient to meet existing needs.

Mr. BENNETT. I think that is what every person is worried about. In other words, I think most of us agree that research in these various diseases can largely be financed through private channels, by private medical scientists and that the Federal Government ought not to duplicate the spending money for such purposes, but the puzzler is: Where do you find out or how do you find out whether private research agencies are being properly financed and can carry out a sufficient amount of research and when the necessity arises for an expansion of the Federal program and the spending of additional Federal funds? That seems to me to be the crux of the whole thing.

Dr. SMITH. One aspect of a solution to this problem is the conferences that are frequently called by the individuals who are interested in the problems. Again, if I may take the liberty of referring to a personal situation, there is a subcommittee of the Therapentic Trials committee of the council on pharmacy and chemistry of the American Medical Association that is interested in the effect of hormones on cancer, in which there is pooled interest of not only several members of this subcommittee but approximately 54 or 56 different clinics throughout the country, and approximately 16 drug manufacturers who are voluntarily submitting whatever supplies are necessary for the investigators in the 56 centers.

Every so often, conferences are held in Chicago so that these people who have been working over the months may pool their ideas. On the basis of that pooling of ideas, it is possible to set up further plans and the individuals then may return to their centers supported by the information that they have received from their coworkers. At the same time they have new thoughts concerning how they may approach their own particular problem. Such conferences have been used by many groups, certainly those that exist under Government auspices and those existing on a voluntary basis. It is only through such cooperation that you can actually get the information that is needed to answer the questions that you raise.

I do not think, Mr. Congressman, at this time, that you could probably set forth the exact sums of money that are needed for any particular project, but I do believe that you can depend upon the cooperation of the various people who are interested in this subject, so that you can get some idea of what is needed.

One of the best ways, of course, to learn whether or not there are sufficient funds for a given disease is to ask the individuals who are experts in that field and who have been working on the subject for years what they need.

Mr. BENNETT. Well, I am leading up to that. Do you think the law that we might pass here might contain some provision whereby the Surgeon General himself would, with private groups, enter these fields, confer with private groups and see whether there is a necessity for a further expansion of Federal research programs in these various diseases?

Dr. SMITH. As a general principle, to make certain that you get the information that is available and needed, I think it is a wise thing for the Surgeon General and others to always consult with the groups that do the work.

Mr. BENNETT. He ought to be required to consult with organizations representing private research.

Dr. SMITH. I believe that they do that now. Am I not right about that?

Mr. BENNETT. That is all.

Mr. WILSON. Mr. Chairman.

Mr. PRIEST. Mr. Wilson.

Mr. WILSON. Mr. Bennett, in his line of questions, has brought up many things that have been in my mind. You have been talking about private funds or funds from private sources being made available for research work. You have been talking about money needed for particular projects. I wonder if you can tell us what those private sources are? Do you have any kind of a compilation that shows what they are?

Dr. SMITH. I do not have one at hand, sir, but some idea of the work now undertaken can be gained from at least two publications, which I am aware of, in connection with recent surveys or foundations that exist in this country, which shows where the money comes from, the subjects that are covered by these contributions and by the foundations.

Mr. WILSON. Dr. Smith, what are those publications and can you make them available for the committee?

Dr. SMITH. I can do that, sir. One is by Rich. The other has been compiled by a foundation, the name of which I forget at the moment, but will be glad to submit to your chairman the names.

Mr. WILSON. Mr. Chairman, I would like to ask leave for those publications to be made a part of the record.

Mr. PRIEST. Without objection, they will be made a part of the record.

May the Chair inquire as to whether they are rather bulky in size?

Dr. SMITH. No; they are books of the average size. My guess is that they are 300 or 400 pages each.

Mr. PRIEST. May the Chair suggest that we reserve them for the files and for the use of the committee rather than reprintitng them in the record. Would that meet with your approval?

Mr. WILSON. With the privilege of inserting pertinent portions of them in the record.

Dr. SMITH. I did not realize that you wanted them for the record. I thought that you wanted them merely for reference.

Mr. PRIEST. They will be available for the use of the members of the committee. I am afraid they are too bulky to include in the record.

Mr. WILSON. Dr. Smith, I would like to pursue this a little further, because it has been in my mind for quite some while; that is, not only what are those sources of moneys that might be made available from private individuals, private institutions, or concerns, but what effort has been made in the past by the American Medical Association or by any other group interested in research to induce people, to convince them, to lead them to submit and make available funds in large amounts for necessary research?

Dr. SMITH. The most impressive attempts have been the educational programs carried out by the voluntary agencies; for example, the infantile paralysis foundation, the American Cancer Society, and many other groups. So many of these foundations arise when a need is demonstrated that, as Dr. Dyer pointed out, one never knows when attention may be focused on a disease. Sometimes attention is not focused on a disease because we have insufficient information to warrant support of a program being focused on it at the moment, but I have before me just a few of the foundations that have been created in the last few years, foundations that have been created because their need has been demonstrated to civic-minded individuals. The number of foundations grows from year to year. I have forgotten the figures on this, Mr. Congressman, but, as I recall, there were something like two dozen new foundations created a year ago or 2 years ago. Some of those foundations are small, but others have rather ambitious programs.

Mr. WILSON. I know in my own State of Oklahoma there has been a foundation set-up sponsored by the entertainment world, by the theatrical people sponsored by the legislature and promoted by the societies there and they are building large facilities. The foundation in Oklahoma is in its beginning; to your knowledge is that being done in other States?

Dr. SMITH. That principle has been followed and is being followed in other States, and, of course, will continue as long as we are able to do it on a voluntary basis. I have frequently talked to Dr. Turner, of your State, about the project that is out there. It is an ambitious program and it is the sort of thing which is good and which has been done on many occasions and which I am convinced will be done in the future. Such a principle provides a spirit of common interest and shows results which simply cannot be estimated in terms of money.

Mr. WILSON. What inducement, and I emphasize that word "inducements," are there for public-spirited people, people that want to furnish funds, and there are many of such fine people in Oklahoma and elsewhere?

If effective and practical inducement were available, they would make private funds available to sponsor and foster research. What present inducements are there to do just that?

Mr. SMITH. The inducements are interest in humantity. All of us must have that since we are following the line of work that we are. Certainly when you serve in a public office you have an interest in humanity. When you serve in a scientific field you have an interest in humanity. However, sometimes it is necessary to make that interest better known and educational programs can do that.

Again I would like to speak not for a society but to offer it as an example. As I recall the figures for the American Cancer Society, 5 or 6 years ago they were raising something in the neighborhood of a little over $100,000. I believe today they have in the neighborhood of something like $54,000,000 to make available for cancer work. Those figures may stand correction, but I believe that they are reasonably accurate. That is an indication of what can be done on a voluntary basis when you generate interest in the population and when you make that population aware of the need for help.

I do not know how you can do it better than through local groups, local community groups, and certainly through State groups. If you can reach what some people call the grass roots level, I am sure you will find in general that the majority of the people will be glad to support a project that is good and sound if you can convince them that there is a need for support.

One of the problems of the educational groups is to show these individuals the need that exists and to explain to them to their satisfaction how they can help.

Mr. PRIEST. Any other questions?

Mr. BIEMILLER. Yes.

Mr. PRIEST. Mr. Biemiller.

Mr. BIEMILLER. I think you pointed out, Doctor, that part of the funds at least of the voluntary organizations go into what might loosely be called educational endeavors which I am not decrying because I am glad it is done. Is there any rough estimate as to the percentage given by voluntary groups that does go into basic research as opposed to educational work?

Dr. SMITH. I am sorry that I cannot answer that because that depends upon the organization, but I do believe that in the majority of scientific groups the amount that is directed to research effort is certainly the larger part, by far the larger part. I would say that it is the exception rather than the rule to find that a large share of money that is taken into foundations is used for educational purposes or administrative purposes.

However, there are times when education efforts must be supported and that can be best done on a voluntary basis. In that way you appeal to human cooperation rather than order.

Mr. BIEMILLER. Is there not today any agency that is integrating the research work that is being done?

Dr. SMITH. No. I think at the moment it is impossible to do that because the research going on today is so broad but no one group could attempt to do that. The National Institutes of Health probably is quite aware of what is going on throughout the country. I know that the American Medical Associaion is aware of the situation and tries to educate and supplement rather than to try to bring together all interests.

Furthermore, in such a project, you would be behind at all times because science today is moving at a tremendous speed.

Mr. WILSON. Will the gentleman yield?

Mr. BIEMILLER. Yes.

Mr. WILSON. Dr. Smith, you spoke a while ago of promiscuous efforts—no concert of effort—is there any organization directing its concerted efforts to bring together and get funds for basic research?

Dr. SMITH. There is no one organization that I know of that attempts to do that. As I replied to Mr. Biemiller, some of us are interested in gathering what information we can, and I think that we have fairly adequate information so that we can encourage work in fields that seem a little weak at the moment, or we can supplement other fields. I do not believe that it would be possible at this time to set up an agency which could gather all that information and hope to have it up to date. It is an extremely comprehensive subject.

Mr. BIEMILLER. As I recall the National Science Foundation bill, in it at least an attempt will be made to evaluate the amount of research work in various fields.

Dr. SMITH. That is right.

Mr. BIEMILLER. That would be an approach and I assume that the National Science Foundation will have the help of the AMA and other groups?

Dr. SMITH. That is right.

Mr. BIEMILLER. That might be one possible approach where we would begin at least to get the work together. I do not think there is any basic quarrel between the members of the committee and any of the witnesses that we attempt to work this out so that there will not be a duplication of effort. We recognize, as explained in the statement by Dr. Dyer, that a certain amount of apparent duplication is not really duplication; that is, there will be people who will be working on identical projects and who might look to the layman to be involved in duplication. Hence, our advisory boards must have technical competent people, so that correct decisions can be made.

Dr. SMITH. It is necessary to have a certain amount of duplication, if for no other reason than to get people to follow in a particular field. But, with each year, there is less duplication because scientists meet, it seems at times, almost daily to discuss problems. No longer do they wait for information to be published in the scientific journals. There have just been concluded 2 weeks of meetings at Atlantic City where individuals of a wide variety of interests were exchanging ideas.

Conferences were held by various interested groups which permit this quick exchange of ideas and efforts so that people can keep to a minimum the duplication of effort. I think, Mr. Biemiller, that is one problem that will tend to work itself out.

Mr. Biemiller. I have the impression that there has been little or no protest of alleged interference with freedom of scientific research in the national institute.

Dr. Smith. No.

Mr. Biemiller. That question has never arisen?

Mr. Smith. Nothing but commendation.

Mr. Biemiller. Just one more point that bears directly on this question and comes back to the points you were making earlier. I have noticed in some of the cities, particularly in the Middle West, that there is a move on to try to integrate the fund raising of the voluntary health organization. Does that problem come under the cognizance sufficiently of the AMA?

Dr. Smith. Not officially but personally I think it is a good move when people with broad interests find that they are following more or less the same path.

Mr. Biemiller. It would seem to me that is a desirable integration.

Dr. Smith. There are certain desirable features but, of course, the one thing to be avoided is domination by one interest. However, I believe that the majority of the people who participate in these groups are sufficiently strong-willed to prevent domination by one group.

Mr. Biemiller. Thank you.

Mr. Priest. Mr. O'Hara?

Mr. O'Hara. Doctor, you touched on something today that has troubled me for a long time and that is that in some of these problems in which there has been legislation from time to time or at least it has been in the public attention so much that the private promoter gets in and collects a share; is that not true?

Dr. Smith. It is inevitable that that problem arises occasionally but I believe, Mr. O'Hara, that it does not last long because such an an individual is soon exposed. I know that the American Medical Association, as soon as it learns of the activities of such an individual publishes facts in the American Medical Association publications. Also the better business groups are interested. I believe that while such an individual may flourish for a while, with today's open-minded approach and with the quick dissemination of news, he does not last long.

Mr. O'Hara. I have had in mind that in the last 4 or 5 years I have seen tremendous drives in the collection of funds by private interests for this or that which I have no doubt in the main have gone to the source to which they are intended, namely, research or treatment.

Dr. Smith. Yes?

Mr. O'Hara. Going to another step which I am concerned about, it does seem to me that certainly money is not just the answer to all of these things. Either public or private contributions. But, so far as the public is concerned, so far as the Congress is concerned, certainly there should be a survey and a solid survey made of the various interests. For example, in dealing with cancer, there is only so much money that can be used by all of the private interests and by all of the public interests.

Now every cent that is needed by way of public contribution should be obtained, but somebody should be passing, some group should be passing, upon how much the public contribution or the tax contribution should be. That could go all the way up and down the scale of research.

Now, the thing that troubles me is the overlapping and the over-enthusiasm and sometimes hysteria creates the idea that if we appropriate a lot of money we will solve cancer and that is not necessarily the answer?

Dr. SMITH. That is true, Mr. O'Hara. And that is why I have emphasized several times in the last few moments that the need for Federal taxation is concerned only with supplementing the work of existing agencies with the exception, of course, of certain problems that now and then arise. I know your next question is, How are we going to determine that need?

Mr. O'HARA. That is right.

Dr. SMITH. In response to Mr. Bennett's question of a moment ago, I replied that I do not know at the moment and I do not believe that anyone knows at the moment just what is needed or will be needed. On the other hand, appropriate studies can be made. In the past there may have been at times fewer studies than there were outbursts of enthusiasm.

Therefore, whenever one is urged to give funds or to undertake research, an important thing to determine is how much is needed. That is why it is most important to know how many deaths there are, how crippling the diseases are, how tragic they are from a community standpoint as well as an individual standpoint. One way in which the parties interested in the problem can be helpful is to undertake or initiate such surveys. As I explained, the American Medical Association always is attempting such studies and I am sure the study sections of the Public Health Service when they collect data, certainly bring together a lot of information even though it may not be set forth in published form. They bring together a lot of information that is helpful in determining whether or not more funds are needed to carry on certain work. It is a problem, Mr. O'Hara, that has not been fully explored. However, I do believe that more and more attention is being focused on exhaustive studies today before a problem is undertaken. Perhaps, one of the problems is to hold back hysteria and enthusiasm before action is taken.

Mr. O'HARA. In modern words, to make a reasonable use of the accelerator and also the careful application of brakes?

Dr. SMITH. That is right.

Mr. O'HARA. Thank you.

Mr. PRIEST. If there are no further questions, we appreciate your statement before the committee and your answers to our questions.

Dr. SMITH. May I thank you for your attention, gentlemen.

Mr. PRIEST. At this point in the record we will incorporate the statement of Dr. Chester D. Swope, of the American Osteopathic Association, and Mr. Lloyd C. Halvorson, of the National Grange.

(The statements are as follows:)

STATEMENT BY DR. CHESTER D. SWOPE, CHAIRMAN, DEPARTMENT OF PUBLIC RELATIONS, AMERICAN OSTEOPATHIC ASSOCIATION ON JUNE 16, 1949, ON H. R. 3943 AND TITLE II OF H. R. 4312 AND 4313 RELATING TO ESTABLISHMENT OF ADDITIONAL INSTITUTES OF HEALTH IN THE PUBLIC HEALTH SERVICE

H. R. 3943 and title II of H. R. 4312 and H. R. 4313 amend the Public Health Service Act to permit the surgeon general, with the approval of the Federal Security Administrator, to establish and abolish additional national research institutes, traineeships and advisory councils in the Public Health Service.

The surgeon general already has authority to establish "such divisions, sections, and other units as he may find necessary; and from time to time abolish, transfer, and consolidate divisions, sections, and other units and assign their functions and personnel in such manner as he may find necessary for efficient operation of the Service," with the approval of the Administrator (58 Stat. 683).

These bills appear to enlarge the authority of the Public Health Service in the following respects:

1. Extends the authority for grants for traineeships in public and other nonprofit institutions.
2. Permits the surgeon general to add national advisory councils, or to change or increase the membership of existing councils to include some persons outstanding in new activities.
3. Authorizes the Administrator to establish not more than 30 positions in the professional and scientific service to effectuate those research and development activities which require the services of specially qualified scientific or professional personnel, the appointments to be made in the classified civil service without competitive examination upon approval "of the proposed appointee's qualifications by the Civil Service Commission."

Permitting the establishment of traineeships in nonprofit institutions for purposes of all institutes is in line with the congressional policy already adopted in the case of the Heart, Mental, and Dental Institutes, and seems consonant with the public interest and the objectives to be attained.

In the establishment of traineeships, it would be necessary for the Surgeon General to prescribe minimum qualifications of eligibility. Quite obviously an applicant would be expected to evidence a background of education and experience that would give promise of the value of the instruction to be provided in the traineeship involved. Certainly, any minimum qualifications which would foreclose eligibility to intrinsically qualified applicants would conflict with the objectives and dilute the efficiency of the program.

Regulations governing National Heart Institute traineeships became effective January 1, 1949. One of the requirements was that an applicant for training shall have received the degree of doctor of medicine. However, the regulations provided that the Surgeon General may waive that requirement if he determines "as to the particular applicant that such noncompliance would not impair fulfillment of the purposes of the traineeship and that either the applicant's qualifications are substantially equivalent to those otherwise required where the applicant possesses special training, experience, and also for service that makes an award particularly appropriate." In that connection, the Surgeon General has already ruled that the fact that a person possesses the degree doctor of osteopathy and not the degree doctor of medicine does not bar him from consideration for a traineeship.

We have confidence in the fairness of the Surgeon General in the assessment of qualifications of osteopathic applicants for traineeships, but we object to the prescription of any such standards as permit osteopathic applicants to qualify only on a noncompliance basis. None of the research institutes legislation has prescribed the degree doctor of medicine as any more a preferred requirement than the degree doctor of osteopathy. In the Healing Arts Practice Act for the District of Columbia, Congress prescribed: "The degrees doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulations" (45 Stat. 1329).

The results of research in osteopathic institutions have been published in the Journal of Neurophysiology, the American Journal of Physiology, the Proceedings of the Society for Experimental Biology and Medicine, and in the Journal of the American Osteopathic Association.

We favor enactment of this legislation.

STATEMENT BY LLOYD C. HALVORSON, ECONOMIST, THE NATIONAL GRANGE ON H. R. 4312 AND H. R. 4313, TITLE II, MEDICAL RESEARCH

1. At its 1947 annual session, the National Grange took the following action on medical research:

"Problems of medical and dental research: Many diseases could be conquered by research. Recommendation: Increased funds on the Federal, State, and local levels to make more research possible should be urged."

2. At its 1948 annual session, the National Grange reaffirmed this action.

3. The tremendous gains made in the field of medicine attest the public value of research, but we must recognize that much needed research holds no promise of monetary gain. In such circumstances, unless someone provides the money the research is not carried out. The National Grange has for many years believed that the promotion and the carrying-on of research is a proper and essential function of the Federal Government. We advocate sufficient Government support to keep this Nation in the front rank in conquering diseases which still unrelentingly plague mankind.

Mr. PRIEST. The Chair has here some reports from the Federal Security Agency, three reports, in the form of letters dealing with legislation before us and without objection, they will be included at this point in the record, as will also a report from the Civil Service Commission, the Veterans' Administration, the Comptroller General of the United States, and the Research and Development Board.

Without objection, all of these will be included at this point in the record.

(The reports are as follows:)

FEDERAL SECURITY AGENCY,
Washington, June 16, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in reply to your letter of April 14, 1949, requesting a report on H. R. 3943, a bill to amend the Public Health Service Act to support research and training in rheumatism and arthritis, multiple sclerosis, cerebral palsy and epilepsy, and other diseases, and for other purposes.

This bill would vest in the Surgeon General of the Public Health Service the authority to establish with the approval of the Federal Security Administrator, one or more research institutes, together with one or more advisory councils, whenever he determines such action necessary to further research and training in some particular disease or group of diseases, including rheumatism and arthritis, multiple sclerosis, cerebral palsy, and epilepsy. Such institutes and councils, if established, would follow generally the pattern set forth in the National Heart Act (Public Law 655, 80th Cong., 2nd sess.). If and when the objective of establishing such institutes has been achieved, the Surgeon General would be authorized under the provisions of H. R. 3943 to discontinue them and to transfer or consolidate their functions elsewhere in the service. Furthermore, the bill would authorize the Surgeon General to take certain other steps in lieu of establishing additional institutes or/and councils. These steps would include expansion of the functions of existing institutes and councils, together with corresponding modifications of their titles. Finally, the bill would authorize the establishment within the Public Health Service of not more than 30 positions for specially qualified research personnel, such positions to carry salaries of from $10,000 to $15,000 per year.

The Federal Security Agency is in complete agreement with the objectives of this bill, as well as with its particular provisions. In fact, we believe that the enactment of this proposed legislation is essential if further development of the research activities of the Public Health Service is to be guided along the most productive lines.

Congress has provided by statute for the establishment of four national medical research institutes—the National Cancer Institute, the National Heart Institute, the National Institute of Mental Health, and the National Institute of Dental Health. These institutes are serving as national centers for a concerted attack upon the diseases which they were established to combat. The success of these institutes has led to proposals for the establishment of additional institutes. In the current session of Congress, bills proposing the establishment of institutes for rheumatic diseases and arthritis, cerebral palsy, multiple sclerosis, and epilepsy have been introduced. It is reasonable to assume that, in the absence of an adequate alternative, interested groups will urge each session of Congress to set up new institutes for additional specific diseases.

While this Agency is in complete sympathy with the objective of expanded research in all of these specific disease entities, we believe that the point of diminishing returns has probably been reached with respect to the continued proliferation of separate research institutes within the Public Health Service. This does not mean that we regard the present research structure or program emphasis of the service as static. Rather, it means that we are gravely concerned less the trend toward separate research establishments for more and more specific disease entities undermine the effectiveness of the research program as a whole. Above all we are convinced that statutory establishment of administrative subdivisions does not permit the organizational flexibility which is essential to cope with new developments and discoveries in the several fields of medical research.

In addition, we believe that if every expansion of some new research field is accompanied by the establishment of one more institute, the result will inevitably be an extravagantly costly structure, with unavoidable overlapping and friction.

H. R. 3943 provides a means of obtaining the advantages while avoiding the disadvantages of statutory categorical institutes. The bill places in the hands of the Surgeon General and the Federal Security Administrator decisions relating to the administrative organization that will result in the most effective attack upon specific diseases. If, for example, research areas are clearly identified as falling within the general scope of an existing institute, the area of activity of that institute may be enlarged. If the disease is of such significance that a new institute should be established the bill authorizes the Surgeon General to set up such an institute through administrative action. He may also establish a national advisory council for such an institute. Finally, the Surgeon General may abolish institutes and advisory councils established pursuant to the bill.

The only amendment we would propose is related to the establishment of National Advisory Councils. The Surgeon General should be empowered to establish such a council and to appoint its members with the approval of the Federal Security Administrator even if he does not believe it necessary to establish an institute. The major problem with respect to a particular disease may be identification of the areas of research that appear to be potentially most productive. It should be possible in this circumstance to set up a National Advisory Council to lay out broad research plans for the consideration of the Surgeon General. Such a group might also advise the Surgeon General as to whether expanded research should be incorporated in existing research organizations or placed in a new institute.

The flexibility inherent in the terms of this bill, with the amendment proposed above, would effectively avoid the rigidity, segmentation, and administrative complexity that would follow the establishment of a series of additional research institutes through statutory action. At the same time, action appropriate to specific diseases could be taken, the importance of these diseases to the national welfare could be effectively established, and the base of support for medical research into the problems of specific diseases widened.

The second major objective of the bill—authorization to pay salaries ranging from $10,000 to $15,000 to not more than 30 specially qualified workers—is critically important to the proper fulfillment of medical research responsibilities already placed upon the Public Health Service by Congress.

The intent of Congress to insure expansion of medical research has been repeatedly demonstrated—most recently by the increases in appropriations for medical and biological investigations. But appropriation of large sums of money will not alone insure that the objectives of Congress will be realized. Authority to pay reasonable salaries to outstanding scientific and professional persons engaged in research is essential if the quality as well as the quantity of medical research is to increase.

The full potentialties of the whole research staff of the Public Health Service can be brought out only if those who guide its research activities combine research talents of the highest order with ability to stimulate others and to administer large programs. This combination of talents is rare. Persons who possess them command high salaries.

It will not be possible for the Service to pay salaries competitive with the compensation which such people can secure outside the Government. But the research opportunities in the Public Health Service are so challenging to men of the highest caliber that they are willing to make some sacrifice in income for the chance to do work to which their lives are dedicated. What they must have is an income that will make the financial sacrifice bearable. Payment of salaries up to $15,000 per year to a limited number of scientific and professional persons engaged in research and development activities of the Public Health Service will make it possible to keep men of the highest attainments who cannot afford to turn down opportunities to double or triple their income, and to attract men who will sacrifice money but who cannot afford to work at the prevailing $10,000 salary ceiling. The maximum possible total cost of the proposed salary increase is $150,000 per year. This is a small investment in terms of the resulting increase in the productivity of the Federal Government's medical research program.

In summary, the Federal Security Agency strongly supports H. R. 3943, with one minor amendment, and recommends its enactment by the Congress.

We are advised by the Director of the Bureau of the Budget that there would be no objection to the presentation of this report to your committee. For your information, we are enclosing a copy of a letter, dated June 15, 1949, from the director of that Bureau to the chairman of the Senate Committee on Labor and Public Welfare regarding S. 1651, the companion bill to H. R. 3943.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington, D. C., June 15, 1949.

Hon. ELBERT D. THOMAS,
Chairman, Senate Committee on Labor and Public Welfare,
Washington, D. C.

MY DEAR SENATOR THOMAS: This will acknowledge your request of April 21 for a report on S. 1651, to amend the Public Health Service Act to support research and training in rheumatism and arthritis, multiple sclerosis, cerebral palsy and epilepsy, and other diseases, and for other purposes.

This bill would authorize the Surgeon General of the Public Health Service to establish, with the approval of the Federal Security Administrator, one or more research institutes, with advisory health councils, whenever he determines such action necessary for effective research and training with regard to the diseases mentioned in the bill. Such institutes, if established, would follow generally along the principles prescribed for the National Heart Institute in Public Law 655, Eightieth Congress. In S. 1651, the Surgeon General would be authorized to discontinue any such institutes when they were no longer needed. The bill would also enable him to take other steps, such as expansion of existing institutes and councils, instead of establishing new institutes and councils. The bill would also authorize the creation of not more than 30 positions within the Public Health Service for highly qualified research personnel with salaries ranging from $10,000 to $15,000 per year.

The objectives of the bill would appear to be meritorious. In the medical research field, the premium is upon the closest possible interchange of information and ideas, and upon flexibility in the assignment of personnel and equipment. To achieve this close-working relationship, the Congress has authorized the construction of a medical research center at Bethesda which is to house in one building scientists and medical doctors working on a wide variety of medical problems. There now exists in the Public Health Service four statutory research institutes and three administratively created institutes—all operating under a parent organization, the National Institutes of Health, which itself conducts general medical research. The research structure in the Public Health Service needs to be flexible and conducive to the interchange of information and ideas. The flexibility provided by S. 1651 would avoid the rigidity and administrative complexity which inevitably result from the creation of a series of statutory research institutes, each for the purpose of doing research in a particular segment of the medical field.

Acordingly, the Bureau of the Budget believes that this legislation merits the favorable consideration of the committee.

Sincerely yours,

F. J. LAWTON, *Assistant Director.*

FEDERAL SECURITY AGENCY,
Washington, June 16, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of June 8, 1949, for a report on H. R. 5046, a bill to amend the Public Health Service Act to support research and training in blindness and eye diseases, and to aid the States in the development of community programs for the control of blindness, eye diseases, and for other purposes.

This bill would establish a National Institute for Blindness and Eye Diseases in the Public Health Service and would authorize the Surgeon General to conduct and promote—directly and through grants-in-aid, fellowships, traineeships, etc.—researches, investigations, public education, demonstrations, and control projects relating to the cause, prevention, and methods of diagnosis and treatment of blindness and eye diseases.

While H. R. 5046 is the only bill currently under consideration by the Congress which addresses itself specifically and exclusively to the support of research and training in blindness and eye diseases, the problems which it raises are the same as those presented by a number of other bills (such as H. R. 62, 1729, 3893, and 1908) which deal with multiple sclerosis, cerebral palsy, epilepsy, and rheumatism and arthritis, respectively.

In brief, while this agency is fully sympathetic with the basic objective of the bill, namely that of stimulating and expanding research and training in this field, we do not believe that it is wise to achieve this objective through the statutory establishment of an additional institute within the Public Health Service. As we pointed out in our report on H. R. 3943 (which proposes an alternative approach) we believe that the establishment of still additional statutory institutions would tend to make our research organization too rigid and unresponsive to changing needs and circumstances. The alternative approach of H. R. 3943, for which we have a strong preference, would permit the accomplishment of all of the objectives of H. R. 5046, while assuring a much greater flexibility in our research organization.

Also, while the Agency is aware of the need for extending and improving organized community programs of blindness and eye-disease control, it believes that this objective can best be accomplished by making Federal aid available in accordance with patterns already established for grants-in-aid to States in this field. Thus, insofar as such control programs are essentially public-health programs administered by State health agencies, we believe that Federal assistance should be made available as part of a comprehensive public-health grant to the States and would recommend for the committee's consideration provisions for extending and improving the existing State-Federal program of public health grants as set forth in title V of H. R. 4312 and H. R. 4313. As for those aspects of community control programs which are integral parts of the vocational rehabilitation of persons afflicted with blindness or eye diseases, we believe that Federal aid can more appropriately be made to the States in accordance with the Federal-State program now established under the Vocational Rehabilitation Act.

For these reasons, we do not recommend the enactment of H. R. 5046 in its present form.

Time has not permitted us to obtain advice from the Bureau of the Budget as to the relationship of this bill to the program of the President.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
OFFICE OF VOCATIONAL REHABILITATION,
Washington 25, D. C.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: I appreciate your invitation of June 8, 1949, to comment on H. R. 5046 which proposes to establish an institute in the Public Health Service for research and other purposes on blindness and its causes.

H. R. 5046 has been reviewed by the Office of Vocational Rehabilitation and our comments are included in those of the Federal Security Administrator which the committee will receive promptly.

Sincerely yours,

Michael J. Shortley, *Director.*

United States Civil Service Commission,
Washington 25, D. C., June 13, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

Dear Mr. Crosser: Further reference is made to your letter of April 4, 1949, requesting a report of the Commission's views on H. R. 3943, a bill to amend the Public Health Service Act to support research and training in rheumatism and arthritis, multiple sclerosis, cerebral palsy, and epilepsy, and other diseases, and for other purposes.

H. R. 3943 would authorize the Surgeon General, with the approval of the Administrator of Federal Security Agency, to establish in the Public Health Service one or more additional institutes to conduct and support scientific research and professional training relating to the cause, prevention, and methods of diagnosis and treatment of particular diseases or groups of diseases (including rheumatism and arthritis, multiple sclerosis, cerebral palsy, and epilepsy) whenever the Surgeon General determines that such action is necessary to effectuate fully the purposes of section 301 with respect to such disease or diseases.

The only provisions of the bill which fall within the Commission's scope of activity are the personnel provisions.

Section 432 of the bill (p. 3) provides that "upon the establishment of an institute pursuant to section 411, the Surgeon General may, if he finds it necessary, also establish a national advisory council to advise, consult with, and make recommendations to the Surgeon General on matters relating to the activities of the institute. Any such council shall consist of the Surgeon General ex officio, and of 12 members appointed without regard to the civil-service laws by the Surgeon General with the approval of the Administrator." These members will hold office for limited terms and are to be selected from leaders in the fields affected.

It is suggested that the figures "411" (p. 3, line 18) be deleted and the figures "431" be inserted in lieu thereof, as it appears that section 432 has reference to section 431, rather than section 411.

Section 4 (b), page 8, reads:

"(b) Section 209 of such Act is amended by adding at the end thereof the following new subsections:

"'(g) The Administrator is authorized to established and fix the compensation for, within the Public Health Service, not more than thirty positions, in the professional and scientific service, each such position being established to effectuate those research and development activities of the Public Health Service which require the services of specially qualified scientific or professional personnel: *Provided*, That the rates of compensation for positions established pursuant to the provisions of this subsection shall not be less than $10,000 per annum nor more than $15,000 per annum, and shall be subject to the approval of the Civil Service Commission. Positions created pursuant to this subsection shall be included in the classified civil service of the United States, but appointments to such positions shall be made without competitive examination upon approval of the proposed appointee's qualifications by the Civil Service Commission or such officers or agents as it may designate for this purpose.'"

In recent years there has been a repeated tendency to cover the needs of the departments and agencies for outstanding professional and scientific personnel by excepting a limited number of positions from the Classification Act of 1923, as amended, in order that the agency may pay more than $10,330. The Commission has no objection in any one individual instance of excepting a limited number of such positions from the Classification Act. However, it does not believe that it is good legislative procedure to enact into law a large number of individual exceptions of this kind.

The Commission is of the opinion that the Classification Act of 1923, as amended, should be revised so as to permit salaries in excess of $10,330 to be paid in proper cases under proper control, and favors general legislation with such safeguards to permit salaries in excess of $10,330 for specialized positions.

Every time legislation is enacted to permit salaries in excess of $10,330 for this type of position in one agency, others having similar needs can be expected to ask for the same thing. We believe that general legislation should be enacted to cover this problem which is not localized but is Government-wide.

In the absence of general legislation to cover this problem the Commission has no objection to the prosposed individual exceptions in this bill.

Section 4 (b) would also give civil-service status to the appointees but would bypass the regularly approved methods of securing civil-service status. The Commission believes that the regular competitive procedures are appropriate and desirable for filling such positions. No reason appears why all qualified and interested citizens should not have an opportunity to compete for appointment to such professional positions. Further, the competitive procedure would minimize the possibility of pressure being brought for appointment of individuals for reasons other than outstanding qualifications.

This type of position is one which very readily lends itself to the activities of a committee of expert examiners set up within the employing agency (in this case the Federal Security Agency) with such assistance of and supervision by the Civil Service Commission as are provided for in applicable civil-service regulations. This method of securing eligibles already has recogniton and official approval as a recruiting device. In past instances wherein the various agencies have approached this system of filling their specialized personnel needs with enthusiasm and good will, the end results have been uniformly good.

The Commission accordingly recommends that in section 4 (b), page 9, the words beginning with "Positions created * * *" through line 7 be deleted, and that the following be substituted: "Positions created pursuant to this subsection shall be filled in accordance with civil-service requirements."

If so amended, the Commission sees no objection to the proposed legislation so far as any matter within its cognizance is concerned.

The Commission, in accordance with established procedure, has been informed by the Bureau of the Budget that there would be no objection to the submission of the proposed report to your committee.

By direction of the commission:

Sincerely yours,

HARRY B. MITCHELL, *President.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., June 15, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of June 8, 1949, requesting a report by the Veterans' Administration on H. R. 5046, Eighty-first Congress, a bill to amend the Public Health Service Act to support research and training in blindness and eye diseases, and to aid the States in the development of community programs for the control of blindness, eye diseases, and for other purposes.

The bill proposes to establish a National Institute for Blindness and Eye Diseases in the Public Health Service and a National Advisory Blindness and Eye Disease Council for the principal purpose of improving the health of the people of the United States through the conduct of research, investigations, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of blindness, eye diseases, and related diseases.

The proposed program would be administered by the Surgeon General of the Public Health Service under the supervision and direction of the Federal Security Administrator and the Surgeon General would be given broad powers to carry out the purposes of the bill. The National Advisory Blindness and Eye Diseases Council would consist of the Surgeon General of the Public Health Service or his representative, the Chief Medical Officer of the Veterans' Administration or his representative, the Surgeon General of the Army or his representative, the Surgeon General of the Navy or his representative, the Chief of the Department of Vocational Rehabilitation, who would be ex-officio members, and 12 members appointed without regard to the civil-service laws by the Surgeon General of the Public Health Service with the approval of the Federal Security Administrator. The 12 appointed members would be leaders in the fields of fundamental sciences, medical sciences, education, or public affairs, and 6 of the 12 would be selected from leading medical or scientific authorities who are outstanding in the study, diagnosis, or treatment of blindness and eye diseases. The Council would act in an advisory capacity to the Surgeon General of the Public Health Service.

The Surgeon General of the Public Health Service would be authorized to make grants-in-aid to States, counties, health districts, and other political subdivisions of the State, and to public and nonprofit agencies, institutions, and other organizations in establishing and maintaining organized community programs of blindness and eye-diseases control. This proposal is similar to existing law (42 U. S. C. 246) with respect to grants to States, counties, health districts, and other political subdivisions of the States for the prevention, control, and treatment of venereal diseases, tuberculosis, and heart disease. The Surgeon General of the Public Health Service would also be authorized to accept gifts for use in carrying out the provisions of the bill pursuant to section 501 of the Public Health Service Act (42 U. S. C. 219).

The bill proposes to establish within the Public Health Service another institute designed to cover one individual segment of research in the field of medicine. The committee may wish to consider the advisability of the development of multiple institutes for research into specific diseases on the ground that it tends to departmentalize research and investigation. Research in one program very often leads to research in another and an institute confined to one field of research might have a tendency to limit the perspective of the workers.

In reference to the form of the bill, it is noted that it contains several technical discrepancies respecting sectional numbering and lettering with apparently some inadvertent omissions from the text of existing law.

Since the Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation, except representation on the proposed National Advisory Blindness and Eye Diseases Council, no comment other than the above is offered. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that office to the submission of this report to your committee.

Sincerely yours,

O. W. Clark
(For Carl R. Gray, Administrator).

General Accounting Office,
Washington, June 15, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

My Dear Mr. Chairman: Further reference is made to your letter of June 8, 1949, acknowledged by telephone June 10, requesting a report on H. R. 5046, Eighty-first Congress, entitled "A bill to amend the Public Service Act to support research and training in blindness and eye diseases, and to aid the States in the development of community programs for the control of blindness, eye diseases, and for other purposes."

The purpose of the proposed legislation is set out on pages 1 and 2 as follows:

"The purpose of this act is to improve the health of the people of the United States through the conduct of researches, investigations, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of blindness, eye diseases, and related diseases; assist and foster such researches and other activities by public and private agencies, and promote the coordination of all such researches and activities and the useful application of their results; provide research and clinical fellowships and training in medical schools in matters relating to blindness and eye diseases, including refresher courses for ophthalmologists, and develop an information center, and assist States and other agencies in the use of, the most effective methods of prevention, diagnosis, and treatment of blindness and eye diseases, and the rehabilitation of those who have been victims of these diseases."

Briefly, in order to carry out the said purpose, the bill would establish in the Public Health Service a National Institute for Blindness and Eye Diseases; authorize the Surgeon General of the Public Health Service to conduct researches, etc., relating to blindness and eye diseases; cooperate with other agencies, etc., in research and control programs; make grants-in-aid to public or private agencies and to individuals for research projects; establish an information center; secure the assistance and advice of experts in the field of blindness and eye diseases; establish research fellowships and traineeships; and authorize the acceptance of donations. Further, the bill would create, and specify the duties of, a National Advisory Blindness and Eye Diseases Council consisting of the Surgeon General of the Public Health Service, the chief medical officer of the Veterans' Administration, the Surgeon General of the Army, the Surgeon General of the Navy, or their respective representatives, the Chief of the Department of Vocational Rehabilitation, and 12 other members to be appointed by the Surgeon General of the Public Health Service, each of the latter 12 members to receive compensation at a rate to be fixed by the Federal Security Administrator, not exceeding $50 per day, while attending conferences or meetings of the Council or otherwise serving at the request of the Surgeon General of the Public Health Service; and, also, an allowance for actual and necessary traveling and subsistence expenses while so serving away from their places of residence. Section 314 of the Public Health Service Act would be so amended as to provide for grants to States, political subdivisions of States, and public and nonprofit agencies, etc., for establishing and maintaining organized community programs of blindness and eye-disease control.

This office has no information as to the need or desirability of the proposed legislation and, therefore, I make no recommendation as to the merits of the bill H. R. 5046.

On pages 10 and 11 of the bill, there are noted references to a "National Advisory Arthritis and Rheumatism Council." Although this office has not made exhaustive research in the matter, it has not been found that any such council has been established. If no such council is in existence, references thereto apparently should be deleted from the bill. Also, it is found that a National Advisory Dental Research Council was established by the act of June 24, 1948 (62 Stat. 598). Presumably, inclusion of such council at appropriate places in the pending bill, H. R. 5046, would be desirable.

Pursuant to your request, two carbon copies of this report are enclosed herewith.

Sincerely yours,

Lindsay C. Warren,
Comptroller General of the United States.

Research and Development Board,
Washington, D. C., *June 24, 1949.*

Hon. Robert Crosser,
Chairman, Interstate and Foreign Commerce Committee,
House of Representatives, Washington 25, D. C.

My Dear Mr. Crosser: Your request for comments on a certain group of bills relating to the Public Health Service has been assigned to me for the preparation of a report on behalf of the entire National Military Establishment. The bills concerned are H. R. 1908, 1912, 1920, 1935, to establish a National Arthritis and Rheumatism Institute, H. R. 1729, 3258, 3645, to establish a Cerebral Palsy Institute, H. R. 5046, to establish a National Institute for Blindness and Eye Disease, H. R. 4030, a National Leprosy Act, and H. R. 3943, a bill to authorize the establishment of special institutes.

The need for Federal support of research in the national interest is, I believe, fully established, and this is evidenced by the interest taken by your committee in the various bills relating to a National Science Foundation. But unless Federal support of research is wisely administered, serious damage can result to the research institutions of the United States, and our general scientific advance can be delayed.

On the basis of years of experience in this field, it is possible to establish certain principles applicable to the handling of such support programs. These may be stated as follows:

(1) Except where the prime purpose of research is to provide an article or process or information to meet a direct need of the Government for its own purposes, then Government research activities should be supplementary to private research activities and should not seek to supplant them.

(2) The Government should not seek to dominate private research.

(3) The Government should so allocate its support programs as to assure that the total research effort in the country as between all the major fields of research is properly balanced without undue emphasis being placed on any one.

(4) Government support should be economically handled.

All of the above bills except H. R. 3943 are inconsistent with one or more of these principles. They each would establish a formal organization devoted to research relating to a particular disease or family of diseases. These organizations would consist of a council and various administrative units such as public information units. They would, therefore be expensive, they would tend to create an unbalance relative to other fields of research, and they might well lead to a form of domination of the private research. This is particularly true of H. R. 4030 which contains a provision that the public health service "is hereby charged with the duty of conducting and supervising the national research effort" relating to leprosy.

Now, there are some advantages to the establishment of special units where it is desirable to focus particular attention upon a given field of research. If you call such special units national institutes, they have greater attraction for eminent but busy men to serve as members, and they have greater power to capture popular support. But they must be carefully handled in order to avoid the maintenance in being of organizations which in fact have outlived their usefulness and to avoid appropriation of funds which cannot effectively be used. In addition, a provision is necessary for adjustment of scope as the researches unconver new areas which are found to bear upon the initial project and conversely, to admit old areas of research which are found to affect the area initially covered by the institute. These attributes are possessed by H. R. 3943. Under that bill, institutes can be established as the need arises, they can be so defined as to match the current state of knowledge, and they can be altered in coverage or abolished to meet changing circumstances. We, therefore, favor the enactment of H. R. 3943 with an amendment to authorize the Surgeon General to abolish presently existing special institutes as well as those to be established under this bill. It follows, therefore, that the other bills discussed in this letter should be disapproved.

This report has been coordinated among the departments and agencies of the National Military Establishment in accordance with procedures established by the Secretary of Defense. Time has not permitted reference of this report to the Bureau of the Budget.

Sincerely yours,

R. F. RINEHART
(For Karl T. Compton, *Chairman*).

Mr. PRIEST. Our next witness this morning will be Mr. Hulen C. Walker, field representative of the American Foundation for the Blind, Inc.

STATEMENT OF HULEN C. WALKER, FIELD REPRESENTATIVE, AMERICAN FOUNDATION FOR THE BLIND, INC., NEW YORK, N. Y.

Mr. PRIEST. The Chair is particularly happy to welcome Mr. Walker. He is a native of Nashville, Tenn., which is the chairman's home town.

I have had opportunity during the years to be acquainted with the great work he has done in the State of Tennessee in the interests of those who suffer from blindness, and we welcome him to this committee today.

Mr. WALKER. Thank you, Mr. Priest. That little statement makes me wonder if you are talking about me or someone else because when you make all those statements, I do not recognize myself.

I would like to ask this committee for the privilege of filing a statement by Dr. R. B. Irwin, who is our executive director for the American Foundation for the Blind.

In the interests of conservation of the time of the committee, I wish to make this statement more or less a joint statement of Dr. Irwin and myself that will cover our position in wholeheartedly endorsing the principle of appropriations for research on eye diseases.

There has been some discussion of H. R. 3943 which by slight amendment might do the same thing that H. R. 5046 would do for the blind but I just want to point out that there are upward of 200,000 blind people in the United States today and more than 84,000 of those people are on some type of Federal relief which runs into a figure of more than $40,000,000, and if certain research was conducted by the Federal Government and the information disseminated to the practitioners and ophthalmologists throughout the country, we feel that that group now receiving assistance from the Government could be materially reduced by this information on eye diseases being passed and cures effected.

There are approximately 30,000 individuals each year that lose their sight and through our organization we have found that possibly 50 to 60 percent of that group could be restored to some usable sight if the information that is now being developed by small groups doing research could be disseminated on a large scale throughout the country.

Just for instance in premature births, today we find that approximately 12 percent of prematurely born babies are blind due to retrolental fibroplasia. A few years ago those babies would have died but today they are blind. Therefore, we feel that extensive research in this field would eliminate the supply of blind people for whom the Federal Government and the States and the other private organizations are having to provide funds for their education and rehabilitation today.

Mr. Priest. I appreciate the opportunity to appear here and due to Dr. Irwin having been called to the west coast I would like to offer for the record his entire statement and again say that we endorse the principle of providing for research on eye diseases and would suggest that H. R. 5046 be recommended as an adequate bill.

Mr. Priest. Mr. Walker, we appreciate your testimony.

Mr. Walker. I will be glad to answer any questions. Any questions that you gentlemen would like to ask, I will attempt in my humble way to answer.

Mr. Priest. Mr. Sadowski?

Mr. Sadowski. No questions.

Mr. Priest. Mr. O'Hara?

Mr. O'Hara. Mr. Walker, I want to express my appreciation of your fine statement in the record and I shall try to overlook the fact that you come from Mr. Priest's home town.

Mr. Walker. I might say that we come from the same city ward, Mr. O'Hara.

Mr. O'Hara. That infers and may be a possible indication that you get together.

Mr. Walker. It has been my pleasure a few times already to get around on election day and I hope that he will live to be in the Congress a long time. I saw in the Nashville paper this morning where a gentleman walked up to obtain a driver's license and the clerk said, "How did you manage to live to be 108?" The reply was, "By minding my own business."

So, I hope that Mr. Priest can live to be 108 and we can vote for him every time.

Mr. O'HARA. Mr. Walker, of course, any legislation pertaining to the Nation's health will be sadly neglectful if it does not include the problem of blindness; and in that connection—and I hope that I am not becoming offensive to the other members of the committee—my own home State of Minnesota has done, I think, an outstanding job in relationship to its own State activities in connection with the problems of the blind. Is that not true?

Mr. WALKER. Yes, sir; it is. Minnesota is one of the outstanding States in work for the blind, both in affecting cures through their public-health service and also in providing rehabilitation training and education for the blind. When you get down to the solving of problems of the blind, you provide employment and that solves a lot of problems.

Minnesota is one of the leading States in the employment of the blind.

Mr. O'HARA. In connection with the medical end of it, of course, Mr. Walker, I presume that there has been some research done and perhaps there is need of additional research as you and Dr. Irwin call attention to in your statements.

Mr. WALKER. Mr. O'Hara, there has been quite a bit of sporadic research, you might say, by different private individuals and private organizations across the Nation; but, as a national agency, we think that this research that has been going on should be coordinated by an institute in the Public Health Service. That would add quite a bit in public relations and prestige, as one gentleman here said a minute ago. When you have a section on eye diseases in the Public Health Service, it centers the attention of the public to the fact that research is being carried on in that particular disability.

The disability of blindness has one of the most sympathetic appeals to the public of any. The reason for that is because it is a visible disability. The general public sees the blind person. They do not see the man with heart disease and things like that—and, in many cases, cancer—but they do see this disability of blindness.

If you have a national institute dealing with research in the eye diseases, it focuses the public's attention to the fact that we are attempting as citizens of this great country to ameliorate the conditions of that particular individual.

Mr. O'HARA. Thank you, Mr. Walker.

Mr. PRIEST. Mr. Stanley?

Mr. STANLEY. No questions.

Mr. PRIEST. Mr. Bennett?

Mr. BENNETT. No questions.

Mr. PRIEST. Mr. Biemiller?

Mr. BIEMILLER. Mr. Chairman, I just wanted to state that I was happy to hear the testimony given by Mr. Walker.

Mr. WALKER. Just as a matter for the record, I would like to state that the American Foundation for the Blind is a private organization. It is dedicated to the promotion of the general welfare of the blind of the United States. It is an organization that is endowed by private individuals, and as of today there are more than 70,000 interested individuals (both sighted and blind) across the country that support this organization.

We do not do medical research. We do technical research, and we do legislative counseling and social research in work for the blind. The medical research would have to be carried on by scientists trained in that field.

Therefore, we are urging the establishment of such an organization.

Mr. Wilson. Mr. Chairman?

Mr. Priest. Mr. Wilson.

Mr. Wilson. Mr. Walker, you mention in the statement that you present for Dr. Irwin, the executive director of your foundation, that, in addition to the sum of $40,000,000 that is being expended by way of relief for some 200,000 people that are blinded in our Nation, there are large sums being used for vocational rehabilitation and those funds are at the expense of the taxpayer. Does your foundation have any figures for any approximate amount expended?

Mr. Walker. On rehabilitation or general?

Mr. Wilson. On the vocational rehabilitation.

Mr. Walker. The Congress of the United States appropriates quite a sum. I think it was probably $18,000,000 for vocational rehabilitation, and that covers the general field.

Now, the blind probably would not be more than 10 percent. That may be more or less a guess, but the Office of Vocational Rehabilitation would have to give us a figure on that as to what is being spent. This $40,000,000 is actually what is distributed throughout by the Bureau of Public Assistance to the needy blind of the country, which is approximately 84,000.

Of that group, the majority are not feasible for rehabilitation purposes at all, due to their age or due to other disabilities along with blindness. For instance, many blinded individuals also have emotional conditions, emotional upsets due to the disability of blindness which in many cases with proper medical care can be remedied or can be cured, even the eye condition. Offhand, I just could not give you a figure as to what is being spent for the rehabilitation of the blind, because in some States it is carried on by the agencies for the blind. In Minnesota, I believe, Mr. O'Hara, the rehabilitation is handled by the State services for the blind?

Mr. O'Hara. That is correct, I believe.

Mr. Walker. In the department of welfare. In other States, for instance, in Arizona and Georgia and places like that, it is carried on by the general rehabilitation service in the department of education; so that in those cases we would not have a figure separate from the general rehabilitation set-up.

Now in 21 States, I believe it is, we have separate agencies for the blind which are handling all rehabilitation services for the blind. In Tennessee we have such a service in the welfare department which administers the aid to the blind and the rehabilitation, workshop, the vending-stand program, under the Randolph-Sheppard Act (Public Law 32, 74th Cong.).

So I could not give you a figure; what I would give you would be more or less a guess. It is part of that $18,000,000 plus State funds.

Mr. Wilson. You spoke awhile ago of a figure of 12 percent of premature children born who are blinded?

Mr. Walker. They are blind due to retrolental fibroplasia. That is a new one on me. I do not know what that means other than that it is a condition of the eye. It seems that the eye is one of the last organs to develop, and when a child is born prematurely in about 12 percent of those cases they are born blind, and there has been no cure found for it so far. A few years ago, Mr. Wilson, those babies would have died, but research has developed the means and methods of saving those little fellows, even though they do not see.

Mr. WILSON. Mr. Walker, you also referred, I believe, to H. R. 5046, that there might be some perfecting or clarifying amendments that your foundation would want to submit?

Mr. WALKER. No; you probably misunderstood me there. I said there has been some discussion of H. R. 3943. I would suggest that in H. R. 3943 it could probably be amended to include the word "blind" along with other diseases.

However, this H. R. 5046 has come out since H. R. 3943, and it carries quite a set-up there under H. R. 5046, which would set up an institute for the purpose of research in eye diseases.

I merely suggested that maybe H. R. 3943 could be amended to do the same things that H. R. 5046 does.

Mr. WILSON. Thank you.

Mr. PRIEST. If there are no further questions, we thank you, Mr. Walker, for your testimony.

Mr. WALKER. Thank you, sir. Dr. Irwin's statement will be incorporated in the record?

Mr. PRIEST. Without objection, that will be done.

(The statement is as follows:)

STATEMENT REGARDING H. R. 5046 BY DR. R. B. IRWIN, EXECUTIVE DIRECTOR OF THE AMERICAN FOUNDATION FOR THE BLIND

I would like to express my hearty approval of H. R. 5046. There are in the United States upward of 200,000 blind people. Over 84,000 of them are on relief at an annual cost of $40,000,000. Thousands more are being educated at great expense in schools for blind children throughout the country, and still thousands more are taking vocational rehabilitation at the expense of the taxpayer.

No one begrudges a blind person any assistance which will help him to become a useful citizen or even alleviate his unfortunate condition. It is shocking, however, when we find that a large percentage of these people are blind from diseases for which there is good reason to believe a cure might be found. About 25,000 people in the United States are blind in both eyes from glaucoma, and probably 150,000 more are blind in one eye from the same disease. A limited amount of research work is being done to find a cure so as to prevent the ravishes of this disease, but the funds for maintaining such research work are pathetically small.

There are several other diseases which are causing total or partial blindness in this country which should be thoroughly investigated. The American Foundation for the Blind earnestly hopes that Congress will take steps to make available funds that will uphold the hands of those who are striving to reduce the amount of blindness in the United States.

Mr. PRIEST. The committee will stand adjourned until 10 o'clock tomorrow morning.

(Thereupon, at 11:50 a. m., the committee recessed to reconvene at 10 a. m., June 17, 1949.)

NATIONAL HEALTH PLAN

FRIDAY, JUNE 17, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., in room 1334, New House Office Building, pursuant to adjournment, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The committee will please come to order.

We are meeting this morning for a continuation of hearings on title II of what we have referred to as the omnibus bill, H. R. 4312 and H. R. 4313. In addition to title II of that bill we also are directing attention to H. R. 4918 and a number of identical bills that also have titles dealing with medical research, and then to H. R. 3943, which is an omnibus medical-research bill, and H. R. 5046, by Mr. Biemiller, which provides for research facilities.

We have several witnesses which the committee is most anxious to hear. We hope we can proceed as expeditiously as possible. We want as nearly as possible to conclude the medical-research hearings some day next week in order that we might go into executive session and consider what might be done in the way of reporting legislation on the subject.

Our first witness this morning will be Mr. William P. MacCracken, Jr., on behalf of the American Optometric Association.

Mr. MacCracken, we are happy to have you as a witness.

STATEMENT OF WILLIAM P. MacCRACKEN, JR., ATTORNEY FOR THE AMERICAN OPTOMETRIC ASSOCIATION, WASHINGTON, D. C.

Mr. MacCracken. Mr. Chairman and gentlemen of the committee, my name is William P. MacCracken, Jr. I reside in Washington, D. C., and am the Washington attorney for the American Optometric Association.

Dr. John B. O'Shea, president of the association, and Dr. William C. Ezell, a former president, have both testified before this subcommittee as representatives of the optometric profession on the general subject of the national health bills.

On behalf of the association I desire to submit specific amendments to both of the bills which are scheduled for hearing this morning. And when I say both of the bills, Mr. Chairman, I mean the one which you introduced on research and the one introduced by Congressman Biemiller, dealing particularly with blindness.

H. R. 3943, while it deals with other than visual problems, is sufficiently broad in its general purposes to permit including optometry specifically within its provisions. That is the purpose of the amendments which are submitted with this statement.

H. R. 5046 deals definitely with blindness and eye diseases. It is our understanding that the author of the bill, Congressman Biemiller, did not intend to exclude optometry from its scope and, in fact, is willing to accept the proposed amendments.

Now, at this point, if I may digress from my prepared statement, I would like to point out, Mr. Chairman, that these amendments, if either bill is passed, it would not be necessary to include them in the other one. In other words, one supplements the other, or rather duplicates it.

There can be no argument but that the conservation and improvement of vision is of vital importance to the public welfare. The modern optometrists are the specialists in this field. They devote from 4 to 5 years of intensive college training in preparing to care for the visual problems of their fellowmen. As these amendments are clearly in the public interest, we trust that you gentlemen of the committee will see your way clear to adopt them. By so doing, the cost will not be increased and the benefit to the public will be substantially greater.

Mr. Chairman, with reference to your bill, there are some 23 amendments, and with reference to Congressman Biemiller's bill there are some 40 amendments.

It is necessary in order to properly cover the matter that wherever blindness or eye diseases are referred to, there should also be inserted the words with reference to improvement and conservation of vision.

In your bill there were not quite so many places where we felt it was necessary to propose amendments, but the general purpose of the amendments to the two bills are identical and perhaps I could best point it out by a statement in connection with the first amendment in H. R. 3943, which we suggest, which has to do with that title and in line 3 of the title, between the words "diseases" and "and" insert the words "to improve and conserve vision," and then in the title to H. R. 5046, in line 2, before the word "blindness," we suggest inserting the word "vision." Then in lines 3 and 4 we suggest striking out the words "for the control of" and insert in lieu thereof "dealing with," so that it will read:

> To amend the Public Health Service Act to support research and training in vision, blindness, and eye diseases, and to aid the States in the development of community programs dealing with blindness, eye diseases, vision, and for other purposes.

And I think those two amendments to the title generally explain the purpose of the other amendments that are submitted.

Mr. Priest. But you wish to include all of the amendments in your statement?

Mr. MacCracken. Yes; without reading them, Mr. Chairman.

Mr. Priest. They are all more or less the same amendment at different places?

Mr. MacCracken. In the bill. It is to carry out that purpose so they can conduct research investigation, and it is for conservation and improvement.

Mr. Priest. The committee is very happy to have your suggestions. They will be put into the record, and I am sure that the subcommittee will give them due attention when we go into executive session to consider the terms of the bill.

Are there some questions?

We thank you so much. You have appeared before this committee a number of times and have always been very helpful to the committee.

Mr. MacCracken. Thank you, sir. It is always a pleasure to appear before this committee. I might say that this is the first committee I ever appeared before, and that was more than 25 years ago.

Mr. Priest. Thank you.

(The amendments referred to are as follows:)

Amendments to H. R. 3943

1. In line 3 of the title, between the words "diseases," and "and" insert the words "to improve and conserve vision".
2. Page 1, line 8, between the words "diseases," and "assist" insert the words "and to improve and conserve vision".
3. Page 2, line 3, after the word "diseases", insert the following: "and defective vision".
4. Page 2, line 6, strike out the period after the word "diseases" and insert the following: "and defective vision."
5. Page 2, line 23, between the words "epilepsy)" and "whenever" insert the language "and defective vision".
6. Page 3, line 1, between the words "ease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
7. Page 3, line 1, after the word "diseases", strike out the period and insert in lieu thereof the following: "or defective vision."
8. Page 3, line 6, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
9. Page 3, line 6, between the words "diseases" and "the" strike out the comma and insert in lieu thereof the following material: "or defective vision,".
10. Page 3, line 9, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
11. Page 3, line 9, between the words "disease" and "and" insert the following material: "or defective vision".
12. Page 4, line 2, between the words "sciences," and "education," insert the word "optometry,".
13. Page 4, line 3, between the words "medical" and "or" insert a comma and add the word "optometric".
14. Page 4, line 5, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
15. Page 4, line 5, between the words "diseases" and "to" insert the words "or visual problems".
16. Page 4, line 25, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
17. Page 4, line 25, between the words "diseases" and "to" insert the words "or visual problems".
18. Page 5, line 18, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
19. Page 5, line 18, between the words "diseases" and "to" insert the words "or visual problems".
20. Page 6, line 4, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
21. Page 6, line 4, between the words "diseases" and "with" insert the language "or visual problems".
22. Page 8, line 10, between the words "disease" and "diseases" strike out the word "or" and insert in lieu thereof a comma.
23. Page 8, line 10, between the words "diseases" and "for" insert the words "or visual problems".

Amendments to H. R. 5046

1. Line 2 of the title, between the words "in" and "blindness" insert the word "vision,".

2. In lines 3 and 4 of the title, strike out the words "for the control of" and insert in lieu thereof "dealing with".

3. In line 4 of the title, between the words "diseaeses," and "and" insert the word "vision,".

4. Page 1, line 3, between the words "for" and "Blind-" insert the word "Vision,".

5. Page 2, line 1, between the words "blindness," and "eye" insert the word "vision,".

6. Page 2, line 6, between the words "medical" and "schools" insert the words "and optometric".

7. Page 2, line 6, between the words "to" and "blind-" insert the word "vision,".

8. Page 2, line 8, between "mologists" and "and" strike out the comma and insert in lieu thereof the words "and optometrists,".

9. Page 2, line 10, between the words "of" and "prevention" insert the words "the improvement and conservation of vision and the".

10. Page 2, line 17, between the words "for" and "Blindness" insert the word "Vision,".

11. Page 2, line 20, between the words "for" and "Blindness" insert the word "Vision,".

12. Page 2, line 25, between the words "to" and "blindness" insert the words "the improvement and conservation of vision and".

13. Page 3, line 2, between the words "Advisory" and "Blindness" insert the word "Vision,".

14. Page 3, line 4, after the word "to", insert the words "the improvement and conservation of vision and".

15. Page 3, line 18, between the words "to" and "blindness" insert the words "the improvement and conservation of vision and".

16. Page 3, line 19, between the words "Advisory" and "Blindness" insert the word "Vision,".

17. Page 4, line 1, after the word "research,", insert the words "on the improvement and conservation of vision and on the".

18. Page 4, line 11, between the words "of" and "blindness" insert the word "vision,".

19. Page 4, line 24, between the words "the" and "diagnosis," insert the words "improvement and conservation of vision and the".

20. Page 5, line 13, between the words "for" and "blindness" insert the word "vision,".

21. Page 5, line 20, between the words "into" and "the" insert the words "the improvement and conservation of vision and".

22. Page 6, line 6, after the word "the", insert the following: "improvement and conservation of vision and the".

23. Page 6, line 12, between the words "the" and "cause", insert the words "improvement and conservation of vision and the".

24. Page 6, line 17, between the words "to" and "blindness" insert the words "the improvement and conservation of vision and".

25. Page 6, line 21, between the words "the" and "cause" insert the words "improvement and conservation of vision and the".

26. Page 7, line 3, between the words "the" and "diagnosis," insert the words "improvement and conservation of vision and the".

27. Page 7, line 10, between the words "the" and "cause" insert the words "improvement and conservation of vision and the".

28. Page 7, line 17, between the words "gists," and "or" insert the word "optometrists,".

29. Page 8, line 1, between the words "to" and "Blindness" insert the word "Vision,".

30. Page 8, line 6, between the words "the" and "causes," insert the words "improvement and conservation of vision and the".

31. Page 8, line 9, between the words "Advisory" and "Blindness" insert the word "Vision,".

32. Page 8, line 13, between the words "Advisory" and "Blindness" insert the word "Vision,".

33. Page 8, line 24, between the words "ences," and "education," insert the word "optometry,".

34. Page 8, line 25, between the words "medical" and "or" insert a comma and add the word "optometric".

35. Page 9, line 2, between the words "of" and "blindness" insert the word "vision,".

36. Page 10, line 7, between the words "and" and "Blind-" insert the word "Vision,".

37. Page 10, line 16, between the words "the" and "Blindness" insert the word "Vision,".

38. Page 11, line 14, between the words "National" and "Blind-" insert the word "Vision,".

39. Page 12, line 2, after the word "National" insert the word "Vision".

40. Page 12, line 16, between the words "programs" and "of" insert the words "for the improvement and conservation of vision and".

Mr. PRIEST. The next witness scheduled to appear is Dr. Daniel A. Poling. He is temporarily delayed. We expect him to be here shortly, but in the meantime, in order that we may proceed, the Chair would like to request that Mr. Adelsheim make his statement at this time.

STATEMENT OF SILAS ADELSHEIM, ACCOMPANIED BY MRS. SILAS ADELSHEIM, PITTSBURGH, PA.

Mr. ADELSHEIM. Mr. Chairman, I am blind and consequently with your permission I would like for Mrs. Adelsheim to read my statement.

Mr. PRIEST. Very well, Mr. Adelsheim.

Mrs. ADELSHEIM (reading). My name is Silas Adelsheim. I am nearly 50 years of age, and have been a lifelong resident of Pittsburgh, Pa. For the past 27 years I have been connected with the Anco Corp. of Pittsburgh, merchandise brokers, and for a number of years have been president of this corporation.

Convinced of the pressing need for more adequate research in the field of eye diseases, I became a member of the board of directors of the National Council to Combat Blindness in 1946. In 1948 I was elected president of this organization, and reelected to this office in 1949. As a member of the Board, and as president, I have devoted much time and effort to this cause and have talked with a number of outstanding eye specialists who further confirm the overwhelming need for funds in order to pursue eye research on a level commensurate with the problems presented.

As an individual afflicted with one of the eye diseases for which there is no known effective treatment, and as president of the National Council to Combat Blindness, I am dedicated to do everything humanly possible to help hundreds of thousands of others similarly afflicted, I feel it my duty to submit the attached statement for the consideration of this committee, and I am grateful for this opportunity.

As a salesman for the Anco Corp., of Pittsburgh, my work required intensive traveling until 1935, at the age of 36, when my vision suddenly began to fail and I was obliged to discontinue traveling.

I consulted many eye specialists in an effort to determine why this was happening to me with the hope of finding some beneficial treatment, and I was shocked to learn there was no remedy and medical assistance could do nothing to prevent my becoming blind, in the brief period of 3 years, I lost all vision except light perception. Although I had to give up certain phases of my work, such as traveling, fortunately I was in the type of business where I could continue in an executive capacity despite limitations forced on me by blindness. I say "fortunately," for I have encountered countless others whose lives were completely devastated and who became economic burdens in the face of a similar situation.

It was not until the work of the National Council to Combat Blindness came to my attention that I became fully aware how tragically neglected in the field of eye research. It is a constant source of astonishment to me to find foremost eye specialists at leading centers frustrated in their attempts to do basic research because practically no funds are made available to them. With few exceptions, it means much deprivation for an ophthalmologist or any of the scientists in related fields to devote time to research.

The more than 600 organizations for the blind have most exclusively devoted themselves to directing public interest and funds toward rehabilitation of the blind instead of trying to get to the root of the problem, which is fundamental research. This situation has not been encouraging to the scientists interested in research, nor has it been of assistance in providing them with funds and facilities necessary to go forward with this work.

The tremendous emphasis on rehabilitation, in my opinion, has led both the Government and the public to feel that the blind are being well taken care of through the many agencies who constantly appeal for funds to aid the blind. The average person, I have found, does not always stop to analyze all phases of the problem and in making his annual or semiannual contribution to one or more of the many agencies for the blind, feels that he is doing his share, and is often certain that his assistance is providing for research needs as well.

How frequently, when approaching a friend or business associate for a contribution to the National Council to Combat Blindness, have I encountered the same replies over and over, replies to the effect that they are already giving to some other organization for the blind and felt that certainly research was included in its program, or, I have found a complete unawareness that research in this field was needed and required support. Unfortunately this is not the case, for the need for dollars for research is vast and basic research is almost completely overlooked. The National Council to Combat Blindness has been valiantly trying to bring this fact to the attention of the public and to enlist its aid, but has found it a difficult task to accomplish because of the psychological effect brought about by the constant stress on rehabilitation.

It is not that we want less rehabilitation or care for the blind, it is that we want the Government and the public to realize that practically no research into the many blinding eye diseases has yet been done. Early Government action to initiate and coordinate an effective research program is one practical solution.

Many of the other diseases you are considering for Federal aid, leave visual marks which is not always the case with blindness. Were you to look into my blind eyes or eyes with serious visual deficiencies, you could not tell there was lack of sight. Loss of sight frequently does not have the outward deformities of other crippling diseases, but the scars are inside the heart and mind and the approach must be changed to alleviate the present element of hopelessness. I do not find fault with the Government or with the public, as no one has heretofore taken the time or trouble to point out this important matter.

I am here to plead that our Government, the most progressive in all the world, and one which is concerned with the welfare and health of its population, establish a National Institute for Eye Research which will eliminate so much unhappiness and suffering for uncounted thousands the country over.

Provide us with teams of scientists such as were put to work on atomic energy, with decent salaries and sufficient facilities, so they can find the answers to many eye problems now considered insoluble.

I cannot sufficiently emphasize the great need for Government action on behalf of the blind and near blind. I hope this committee will not fail us in their recommendation to Congress.

Mr. PRIEST. Mr. Adelsheim and Mrs. Adelsheim, we appreciate very much your statement before the committee.

I notice on the last page of your statement you make reference to the importance of some action that would remove what you refer to as the present element of hopelessness.

I think perhaps that is more or less the keynote insofar as considering this legislation is concerned. I think it is true that in the past a great many people have taken the attitude that where a person suffers the loss of sight or visual defects that it has been more or less hopeless. I am of the opinion that it is not, just as I was in the case of mental health and the attitude toward mental health which has prevailed for a long time, that nothing could be done about an individual who suffered from mental illness except just to carry along patiently as long as possible, but that there could be no improvement in his condition. I am sure that the committee has heard with a great deal of interest your statement.

Are there any questions by the members of the committee? Mr. Biemiller?

Mr. BIEMILLER. Mr. Chairman, research in diseases of the eye and resultant blindness is practically a wide open field for research. Very little has been done.

The last estimate I had was that there were about 600,000 people in the country who were suffering from some form of eye disease, and about 260,000 of those are competely blind.

Now, my figures show—and I would like to know if these check with Mr. Adelsheim's figures, that only $70,340 has been granted for research in this field from the National Institute of Health and that would be in connection with ancillary work and major projects; and the best estimates which I have of the private or voluntary agencies are only spending about $400,000 a year for research in this field.

Does that check with the figures your organization has?

Mr. ADELSHEIM. I am sure they check, gentlemen, but I would rather not go into those figures because other statements that are to follow mine, sir, will give you more complete information.

You will note I omitted from my statement all facts and figures. I only tried to point out the psychological fact that our good Government and the Nation, the people, have been very sympathetic to the blind. They have been very blind. They have supported these 660 organizations who shelter, rehabilitate and educate, but they do not take the practical approach, and we think that your bill does take a practical approach.

I was very glad to hear Mr. Priest say that he did not feel that it is hopeless and that research can do the job. That is what we are interested in.

We feel if you will allocate the funds for fundamental basic research to conserve and prevent eye diseases and blindness it will be the first step that this country has ever taken in doing anything like that is a proper direction.

I do not attempt to evade your question, Mr. Biemiller, but I know the other witnesses will give you all of the information you ask.

Mr. BIEMILLLER. That is very satisfactory.

Mr. PRIEST. Are there any further questions?

Mr. WILSON. Mr. Chairman.

Mr. PRIEST. Mr. Wilson.

Mr. WILSON. You spoke of the element of hopelessness. It impressed me, and I am sure it does my colleagues on this committee. And the presence of men like Mr. Walker yesterday, and Mr. Adelsheim this morning, encourages the members of the committee and the Members of Congress to do something about it and remove the hopelessness.

The very fact that they are so energetically attacking the problem encourages us.

Mr. ADELSHEIM. Thank you, Mr. Wilson.

Mr. PRIEST. We appreciate your appearance before the committee and wish you well in the future.

Mr. ADELSHEIM. Thank you.

Mr. PRIEST. Miss Mildred Wiesenfeld will be our next witness.

Miss Wiesenfeld is executive director, National Council to Combat Blindness. That is correct?

STATEMENT OF MISS MILDRED WIESENFELD, EXECUTIVE DIRECTOR, NATIONAL COUNCIL TO COMBAT BLINDNESS, INC., ACCOMPANIED BY DR. ISRAEL LIGHT, WASHINGTON, D. C.

Miss WIESENFELD. That is correct, Mr. Chairman.

Mr. Chairman and members of the committee, because my vision has diminished to the point that I am unable to read, I have asked someone to accompany me here, and, with your permission, to read my statement to you.

Mr. PRIEST. Very well.

Miss WIESENFELD. I will ask Dr. Light to read my statement.

Mr. PRIEST. Very well.

Dr. LIGHT (reading). Mr. Chairman and members of the committee, my name is Mildred Wiesenfeld. My position is executive director of the National Council to Combat Blindness, Inc. The address of the organization is 1186 Broadway, New York 1, N. Y.

My duties: As executive director of the National Council to Combat Blindness, I am responsible for coordinating the various functions of this organization, which are as follows:

1. Education: To arouse public interest in the need for research into blinding eye diseases and visual impairments.
2. Case service: As related to eye research and treatment.
3. Field study: To determine current needs and activities in the field of eye research and treatment.
4. Supplemental research: To coordinate and cooperate with research efforts in the field of ophthalmology.
5. Fund raising: To obtain suport for the stimulating and financing of research.

Since the inception of the National Council to Combat Blindness 3 years ago, as founder and executive director I have voluntarily devoted myself completely for this period to this work, with the assistance of members of the ophthalmological profession and interested lay individuals. I have talked with numerous specialists in the field, have been in touch with staff members of hospitals, and have had correspondence and personal interviews with innumerable eye sufferers.

With your permission, may I present my statement for the record? I am grateful for the opportunity to do so as an individual vitally interested that a national institute for eye research be established for the reasons given in this statement.

I should further like, with your permission, to give a brief summation of some of the facts that I have gathered.

If I may, I would like to begin by telling you a little of my own personal experience. At a very early age I learned that I had the eye disease called retinitis pigmentosa, which leads to total blindness. In an effort to save my sight, I had visited foremost eye specialists, both here and abroad, including some of the outstanding eye centers. However, no beneficial treatment was available—not even one which would arrest my condition short of blindness.

In succeeding years I found that retinitis pigmentosa was but one of the many existing eye diseases which was baffling the medical profession and taking the sight of untold thousands. Several years ago I began to ask questions—many questions—and found to by astonishment that research into these eye diseases was deplorably meager, and that there was, in addition, a startling lack of organization in the over-all field encompassing research in blinding eye diseases. I found that specialists eager to go forward with research did not have the funds with which to do so, nor could they obtain the necessary assistants and equipment needed for a research program. I refer to specialists associated with some of the foremost medical colleges in our country.

It was when I found that a special study into the eye disease which I have could not be undertaken because of lack of funds that the problem became acutely emphasized to me and I began to take some action.

I started by studying the field of the blind and found that there were more than 600 organizations for the blind—all devoted to collecting and spending funds for the rehabilitation and education of those already blind, but not for basic research geared to save the sight of those thousands with failing vision. I regret that I cannot tell you how many thousands of people in our country are faced with impending blindness for there is no accurate figure available. May I refer you to enclosure I, section 1, fact sheet, and the references it contains? You will note that these figures—which have been obtained with much difficulty and effort—are, at best, scant and not all-inclusive. For example, the fact sheet states that 19,000 persons go blind annually, but this is a figure released in 1941, and authorities tell us that blindness is definitely on the increase as our life span is extended. I know you will find it revealing, when you further study the fact sheet, that private funds spent annually for scientific research in blindness total approximately only $400,000, and that a mere $70,340 has been made in Federal grants to date by the National Institute of Health.

Some 3 years ago I took steps in an attempt to remedy this unfortunate situation, and was instrumental in founding the National Council To Combat Blindness. Those of us who conceived the idea of this organization, which would devote itself to collecting funds and distributing these funds for medical research, did not foresee at the inception the vast amount of public education necessary to sufficiently stimulate voluntary contributions for this purpose.

The public had been taught and trained to think of blindness as hopeless, and its giving had been directed almost exclusively to rehabilitation. I am sure that if we had available the amount spent annually on education, rehabilitation, and welfare aid to the blind by private, State, and Federal agencies, the figure would be staggering. I submit one figure which I believe will bear this out. On welfare aid alone to the blind, Federal, State, and county governments spent, during the fiscal year of 1948, $38,540,000, as contrasted with the $70,340 spent to date on research by our Government. Certainly much of the welfare aid expenditure could be eliminated if adequate attention were given to the basic problem—the causes, treatments, and cures of eye defects leading to impaired sight, and eye diseases resulting in blindness.

I am convinced that while a private agency, such as the one with which I am associated, can be of tremendous value in educating the public to the need for supporting medical research, and, with more public education, can eventually raise substantial funds to aid in this effort, the immediate need is for Federal assistance.

I have been in contact with many people who have a sincere desire to give their support to ophthalmological research, but who become overwhelmed by the immensity of the need, and who are discouraged by the present lack of coordination in the field and by the shortage of trained workers to carry on a comprehensive research program. In addition, this discouragement is deepened by the unwillingness of specialists in the field to devote themselves to research because of the woefully inadequate financial remuneration, if any, available to them.

I wish to go on record in stating that only with the immediate, active assistance and support of the Government can this deplorable situation be remedied in our time. I am confident that the members of this committee—and Congress—once award of the need, will take immediate action on behalf of the thousands of men, women, and children among us who are threatened with blindness, the uncounted thousands who are destined to fall victim to any one of the many blinding eye diseases for which there are today no beneficial treatments, the children still unborn doomed to blindness because of their heritage of certain diseases, and the more than 60,000,000 of our population who have defective vision.

With your permission, Mr. Chairman, I would like to outline the facts which I have secured through correspondence, interviews, and study.

1. There has been no coordinated, all-inclusive study into the causes of blindness.
2. There has been no comprehensive and organized survey conducted to determine the amount and disposition of funds expended for ophthalmological research. (See enclosure 2.)
3. The emphasis in the field of blindness has been on rehabilitation rather than treatment and cure, and no single lay organization except the National Council To Combat Blindness exists in the country today devoted chiefly to the education of the public to the need for ophthal-

mic research and for raising funds on a national scale. (See enclosure 3.)

4. The great need for funds for ophthalmic research in our leading universities and medical centers is attested to by doctors prominent in the field of ophthalmology.

I want to read one statement, which is enclosure 4, an excerpt from an address before the section on ophthalmology at the ninety-sixth annual session of the American Medical Assocation, Atlantic City, June 12, 1947:

AMERICAN OPHTHALMOLOGY DURING THE PAST CENTURY

(F. H. Verhoeff, M. D., Boston)

[Archives of Ophthalmology, April 1948, p. 463]

> In view of the great wealth of this country and the strong appeal made by blindness, it is remarkable how little has been donated to ophthalmic hospitals and for ophthalmic research (enclosure 4).

And, upon request, I shall be happy to submit additional information.

(The data submitted above is as follows:)

[Enclosure 1]

FACT SHEET

WHAT ARE WE DOING ABOUT BLINDNESS AND EYE DISEASES?

I. How many people are suffering from blindness and eye diseases in the United States?

1. It is estimated that 600,000 people are severely visually handicapped, and of this number, 259,000 people are suffering from blindness.[1]

2. About 19,000 persons in this country lose their sight annually.[2]

3. An estimated 4,500,000 children in American schools require eye care, and a large number of these children have to wear glasses.[3]

4. An estimated 800,000 persons have glaucoma without knowing it and may go blind at any time.[4]

II. What is being done to detect blindness and eye diseases?

1. There are only about 166 hospitals with residencies in ophthalmology approved by the American Medical Association.[5]

(*a*) This is in contrast with the fact that there are 3,069 counties in the United States, and a large majority of counties should have some type of eye clinics.

III. How many doctors specialize in blindness and eye diseases?

1. There are 1,700 oculists certified for practice by the American Board of Ophthalmology. It is estimated that there are about 4,000 more doctors of medicine who treat the eyes and do some eye surgery.[6]

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[1] Ralph G. Hurlin, chairman of the Committee on Statistics of the Blind. Estimates of Blindness in the United States, Social Security Bulletin, March 1945, vol. 8, No. 3, p. 18.

[2] Rollo H. Britten, Blindness, as Recorded in the National Health Survey—Amount, Causes, and Relation to Certain Social Factors, Public Health Reports, reprint No. 2332, vol. 56, No. 46, November 14, 1941, pp. 2191–2215.

[3] Dr. Franklin M. Foote, executive director of the National Society for the Prevention of Blindness. (Estimate made from survey made by correspondence with State commissioners of education in September and October 1948).

[4] Estimate based on survey made by Philadelphia Committee for the Prevention of Blindness (local chapter of the National Society for the Prevention of Blindness) over a period of about 2 years and reported by Dr. Brav at a meeting in New York on March 18, 1948. The study was made of 4,000 people over 35 years of age and the percentage of this group, found to have glaucoma without knowing it, was used as the basis for the percentage of all persons over 35 years in the United States who probably have glaucoma without knowing it and may go blind at any time.

[5] Dr. Franklin M. Foote, National Society for the Prevention of Blindness. (Statement made by letter dated March 10, 1949, also by telephone April 1949.)

[6] Directory of Medical Specialists, 1946.

IV. How much money is available for research to find new treatments and cures for blindness and eye diseases?

(*a*) *Government funds.*—(1) Only $70,340 has been distributed for this purpose by grants from the National Institutes of Health.[7]

(*b*) *Non-Government funds.*—(1) It is estimated that there is approximately $400,000 being spent annually for medical research in blindness and eye diseases by voluntary agencies.[5]

V. How does this compare with what we spend on other things?

1. In contrast with the total of about $470,340 which is available from public and private sources for research for new treatments and cures for blindness and eye diseases:

(*a*) We spend approximately: (1) $165,000,000 for phonograph records;[8] (2) $287,200,000 for flowers, seeds, and potted plants;[9] (3) $85,000,000 in nonvending coin machines[9] (receipts minus pay-off); (4) $32,400,000 for veterinary service and purchase of pets;[9] (5) $60,600,000 for monuments and tombstones.[9]

VI. What approaches are currently available in medical research which might be expected to reduce the number of persons who may become blind?

1. *Fundamental research.*—These include application of recent advances made in biochemistry, physiology, heredity, nutrition, and infections including immunology and epidemiology, to determine the mechanism of the underlying disorder which is associated with diseases of the eye leading to blindness.

2. *Clinical research.*—(*a*) Direct study of the patient to determine the underlying causes of blinding diseases the most common of which are cataract, glaucoma, uveitis, retinitis pigmentosa, and retrolental fibroplasia; (*b*) study of the response of the patient to proposed new treatments to determine their effectiveness.[10]

VII. What are the main causes of blindness and eye diseases?

1. About 25 percent of blindness is caused by infectious diseases, affecting all ages.
2. About 15 percent trauma (injury).
3. Cataract, about 25 percent, mostly affecting people over 60 years of age.
4. Glaucoma, 12 percent, striking people over 35.
5. Myopia (malignant), about 3 percent, all ages.
6. Retinal degeneration, about 3 percent, all ages.
7. Structural anomalies, about 3 percent, all ages.
8. General diseases, 6 percent.
9. Other congenital or hereditary diseases, 6 percent.
10. Poisoning and neoplasms, 2 percent.

[Enclosure 2]

Excerpt from letter of March 10, 1948, to the National Council to Combat Blindness, Inc. from the National Research Council, Washington, D. C.:

"This is to transmit to you the comments of the Committee on Ophthalmology regarding the requests contained in your letter of February 2.

"The committee regrets that it knows of no way in which this information could be obtained without an extensive survey, which it is not in a position to undertake. * * *

"Very truly yours,

"LEWIS H. WEED, M. D., *Chairman.*"

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[5] Dr. Franklin M. Foote, National Society for the Prevention of Blindness. (Statement made by letter dated March 10, 1949, also by telephone April 1949.)

[7] Dr. David E. Price, Chief, Division of Research Grants and Fellowships, Federal Security Agency, U. S. Public Health Service, National Institute of Health, Bethesda, Md., letter dated January 31, 1949.

[8] Department of Commerce (New York Times, March 31, 1947).

[9] America's Needs and Resources, published by Twentieth Century Fund, 1947.

[10] Estimate based on personal survey of V. E. Kinsey, Harvard Medical School.

As to references (1), (2), (3), (4), and (5) the information given is based on these references, but the estimates have been brought up to date for 1949 by Dr. Franklin M. Foote, National Society for the Prevention of Blindness. (Statements made in personal communications with Dr. Foote in March and April 1949.)

All other information obtained from Dr. Franklin M. Foote, National Society for the Prevention of Blindness.

[Enclosure 3]

REPORT OF SURVEY MADE BY J. M. ULMER, MEMBER OF THE LAW FIRM OF ULMER, BERNE, GORDON & GLICKMAN, CLEVELAND, OHIO

The following data is taken from letters, printed matter such as annual statements of the several groups, and from the Directory of Activities for the Blind, 1947 edition, compiled by Helga Lende of the American Foundation for the Blind, Inc., and other sources of the same type.

1. NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS, INC.

1790 Broadway, New York 19, N. Y.
Organized 1915; incorporated 1918.
Dr. Franklin M. Foote, executive director.

The purposes of this organization, as stated by Helga Lende at page 14 of the Directory of Activities for the Blind (seventh edition) are:

"Ascertains the causes of blindness and impairment of vision; advocates and promotes measures for the elimination of such causes; cooperates with the medical and other professions concerned directly and indirectly with the protection and preservation of sight."

Page 10 of the society's 1946 report indicates income of $224,000, expenditures $195,000; not one dollar spent for research.

"The society's main service, including preparation and distribution of material such as vision testing charts, films, and publications, is rendered through the work of an executive staff."

In letter dated February 14, 1947, they state that research is not the function of the organization.

Letter of August 21, 1947:

"Our primary interest is in the prevention of blinding diseases of the eye and the promotion of eye health.

"The major portion of expenditures are related to educational activities and the promotion of community programs for sight preservation and the prevention of blindness."

During 1947 $500 was appropriated for a study of the treatment of syphilitic optic atrophy, conducted in cooperation with Indiana University School of Medicine, and $2,500 for a study of the relationship between German measles in expectant mothers, etc., in connection with the University of Kansas School of Medicine.

Part of the permanent staff is engaged in long-range study of the causes and extent of blindness. Compared to the dollars collected, the few expended for fundamental research is clearly apparent. In 1948, $20,500 was appropriated for research. What portion of that sum was actually devoted to research as against office maintenance, etc., is not clear. Note 1947 summary of finances, page 10 of the thirty-third annual report, which indicates (and it probably will not be disputed) that very little of the funds expended were devoted to fundamental research.

2. AMERICAN FOUNDATION FOR THE BLIND, INC.

15 West Sixteenth Street, New York 11, N. Y.
Founded and incorporated, 1921.
Robert B. Irwin, executive director.

Its purpose, as stated in the Helga Lende Directory of Activities for the Blind (seventh edition), page 7, follows:

"Disseminates information regarding all phases of work for the blind; promotes State and Federal legislation in behalf of the blind; develops and sells at cost special appliances for their use; arranges for the establishment and improvement of needed agencies for the blind throughout the country; assists in increasing the efficiency of work for the blind through professional training courses for teachers and other workers for the blind; conducts a special department to deal with the problems of the deaf-blind; cooperates with the Army, Navy, and Veterans' Administration authorities charged with the rehabilitation of war-blinded service personnel, and with other Federal agencies working with the blind; awards scholarships; maintains reference and lending library."

Re letter August 1947: "Matters relating to the prevention of blindness have been allocated to the National Society for the Prevention of Blindness, Inc."

In the annual report of 1946 one finds the foundation's activities and services are aimed at lessening for the blind some of the burdens they are obliged to carry on their way through life.

"Research laboratories are continually developing or discovering new daily living aids for the blind."

Fine work is done by the group, but no money is spent for research so far as could be ascertained.

Letter of July 1948: "The function of the American Foundation for the Blind is to work with persons who are already blinded. Since the national society works to find the causes of blindness, its prevention and cure, there would be a duplication of the effort."

A study of the 1947 audit indicates that, out of approximately $358,000 collected, comparatively no dollars were spent for research. This financial statement indicates that endowment funds exceed $2,000,000.

3. THE NEW YORK ASSOCIATION FOR THE BLIND

111 East Fifty-ninth Street, New York 22, N. Y.

Founded 1905, incorporated 1906.

Philip S. Platt, Ph. D., executive director.

On page 71 of the Helga Lende Directory of Activities for the Blind (seventh edition) it is noted that this association:

"Serves the blind of all ages, regardless of race or creed, in Greater New York, except Brooklyn, managed by board of directors, maintained by private funds, over 100 employees (exclusive of workshops).

"Twenty-eight services are rendered to the blind in the fields of adjustment, training, employment, and recreation, summer camps, workshops, etc. A local nonmedical service agency for the blind."

As stated in letter of December 1947 from Philip S. Platt: "We do not engage in medical research. We are a local nonmedical agency for the blind."

4. NEW YORK GUILD FOR THE JEWISH BLIND

1880 Broadway, New York 23, N. Y.

Started 1914.

Mrs. Sidney Pollack, administrative director.

On page 71 of the Helga Lende Directory of Activities for the Blind (seventh edition) it is noted that it—

"Serves Greater New York, New York State, and other States as required, maintained principally by private funds. Case-work service and consultation for blind and their families, financial assistance, eye and medical care, home teaching and guide service, recreation, and educational center, summer camp, workshop, etc."

Provides a home for Jewish blind.

From letter dated August 22, 1947:

"The work of our agency is primarily in the field of giving help to those who are already blinded or who have visual problems of one kind or another. Research programs are carried out in hospital settings, etc., and it would only be a duplication if we were to sponsor any research programs."

Out of the $675,000 collected in 1946, none of this sum (so far as one could ascertain) was devoted to research.

5. THE EYE-BANK FOR SIGHT RESTORATION, INC.

210 East Sixty-fourth Street, New York 21, N. Y.

Mrs. Aida de Acosta Breckinridge, executive director.

Founded 1945.

On page 11 of the Helga Lende Directory of Activities for the Blind (seventh edition) it is stated:

"Maintained by public subscriptions. Aims to make available to hospitals and surgeons who are qualified to perform the corneal-graft operation corneal tissue, wherever and whenever needed."

Their work is specifically devoted to certain types of cases but definitely is not a research organization although this group must necessarily do some research work in the furtherance of their purpose.

6. THE OPHTHALMOLOGICAL FOUNDATIONS, INC.

301 East Fourteenth Street, New York 3, N. Y.

Conrad Berens, M. D., managing director.

This group is engaged primarily in scientific research; recently organized; has an ambitious program but short of funds required for general research.

7. THE INSTITUTE OF OPHTHALMOLOGY OF THE PRESBYTERIAN HOSPITAL

635 West One Hundred and Sixty-fifth Street, New York 32, N. Y. (A division of the Presbyterian Hospital.)

John H. Dunnington, M. D., director.

From a letter from Dr. Dunnington and from a personal interview with Dr. Russell J. Nicholl, formerly connected with the Institute and now at 224 Carnegie Medical Building, 10515 Carnegie Avenue, Cleveland, we find that this group is devoting its efforts to fundamental research but is restricted because of lack of funds for the doing of many things which should be done in fundamental ophthalmic research.

8. UNITED STATES OFFICE OF EDUCATION, FEDERAL SECURITY AGENCY

Office of Vocational Rehabilitation, Washington 25, D. C.

In letter dated October 6, 1947, they say:

"Our work is with persons who are entirely blind or nearly blind. We do not have a program or budget allocation for research in the prevention of eye diseases or blindness."

9.UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY

Washington 14, D. C.

Thomas Parran, Surgeon General.

Compiled list of references on blindness.

Compiled report on the national health survey on the amount, causes and relation of blindness to certain social factors.

Activities directed toward improving facilities for the social eadjustment of the blind rather than toward fundamental research.

GENERAL

Out of the large sums collected throughout the country, it is evident that many organizations and foundations listed in the Helga Lende Directory of Activities for the Blind provide day-today help to the blind—braille, guide dogs, care, rehabilitation through training, etc. But very few devote any moneys to fundamental research to find the causes to prevent and cure blindness.

It goes without saying that fine work is generally done in providing technical aid to enable the blind and agencies for the blind to help themselves. A reading of the purposes of the various groups in the United States listed in the Helga Lende Directory indicates that the soundness of the premise of the field for research to find the causes and prevention of blindness by research is woefully inadequate.

Special attention is directed to the National Council to Combat Blindness, Inc., Suite 432, 1186 Broadway, New York 1, N. Y.

Organized 1946.

Miss Mildred Wiesenfeld, executive director.

They definitely state their purpose to be: "To finance new research projects at established medical centers, etc., to preserve and restore sight through medical research and treatment, prevent and cure blindness by discovering its causes."

This organization, however, has been limited in its activities because of inadequate funds.

[Enclosure 4]

Excerpt from an address read before the section on ophthalmology at the ninety-sixth annual session of the American Medical Association, Atlantic City, June 12, 1947:

"AMERICAN OPHTHALMOLOGY DURING THE PAST CENTURY

"(F. H. Verhoeff, M. D., Boston)

"[*Archives of Ophthalmology, April 1948, p. 463*]

"In view of the great wealth of this country and the strong appeal made by blindness, it is remarkable how little has been donated to ophthalmic hospitals and for ophthalmic research."

Mr. PRIEST. Miss Wiesenfeld, I want to congratulate you for a very well-organized and documented statement. The exhibits, and the fact sheets that you have submitted for enclosing in the record in connection with your statement are very helpful.

Are there any questions?

Miss WIESENFELD. Mr. Chairman, I have an additional enclosure presenting very briefly a case which I think is very pertinent and will serve to give this committee a further insight into the problem of blindness and how far reaching that problem can be. I wonder if Dr. Light might read that. It is brief and will not take too much time.

Mr. PRIEST. Is it a part of your statement?

Miss WIESENFELD. Yes.

Mr. PRIEST. Yes; you may proceed, Doctor, and read the statement.

Dr. LIGHT (reading). In the year of 1938 I was enjoying the blessing of normal vision, and, after 8 years of preparation and study for the profession of dentistry, had opened my office. My future as a useful and productive citizen seemed assured.

Two years later, just at the point when my efforts to build a successful dental practice were reaching achievement, with comparative suddenness I noticed some difficulty in seeing at night and in dim light. Being well aware of the advantage of early diagnosis and prompt treatment of any deviation from the normal, I immediately consulted an eminent eye doctor, expecting nothing more than some minor disorder as night blindness, which could be attended to with ease.

However, his blunt but factual diagnosis was shocking and startling. "You have," said he, "a slow but progressive degeneration of the retina which leads to total blindness. It is known as retinitis pigmentosa." My frenzied questions as to cause, treatment, method of stopping the degeneration short of blindness were all answered in a negative vein. We do not know the cause, there is no effective treatment, we cannot stop the progress of the disease. The response to my next question as to whether any particular study or research was being conducted was another "no." This last "no" dispelled any vestige of hope I may have had that future, new studies would come to my aid and save me from total blindness.

The ensuing 9 years were a steady but futile procession from doctor to doctor, with much self-denial on the part of my family and self due to the fact that so much of my income was being expended on medical consultations.

With the passing of time, my field of vision narrowed down to 7°, whereas the normal eye has a 90° field. This means when I am looking at your eyes while speaking to you, I cannot see your chin or your ears, and as a result, encounter many difficulties in getting about. In other words, it is as though I were constantly looking through a narrow tube. Can you imagine the ordeal of attempting to function normally under this condition?

Persons like myself, having this type of limited vision, are considered blind by our Government. Yes, this disease has a strange phenomenon inasmuch as often the remaining vision, though pinpoint in radius, is sharp and accurate. For example, though I am considered legally blind, I am able to efficiently carry on as a practicing dentist.

However, this situation makes for a tremendous amount of mental strain on my part, as well as for economic and social insecurity. I must, at all times, endeavor to conceal the status of my vision, for my patients would never understand and grasp the incongruity of why I may miss an extended hand in greeting, stumble over objects out of my line of vision, find it difficult to get about at night or in dim light and yet be able to attend to the most minute dental procedures.

It has therefore been necessary for me to almost completely withdraw from normal social life, as I would quickly be discovered because of my visual clumsiness. This, in addition, has meant not being able to attend meetings and social gatherings of any kind, all so necessary for professional progress. As a result, my income is drastically curtailed, and potentiality for any upswing almost nil. Yet, as long as my central vision remains undisturbed, and I can efficiently administer to my remaining patients' needs and earn some livelihood from the profession for which I am trained, I must continue under this strain of secrecy and social seclusion.

Added to this, there is the ever-persistent question as to how long it will be before the sight I still retain is obliterated, and it will become necessary for me to make the adjustments for a life of darkness, and possibly become an economic and social burden.

But even until that final day of total blindness, there is no rest, for there is a continuous diminishing of vision which requires frequent new adjustments.

There are little constant reminders throughout the day—colliding with someone who brusquely chides, "Can't you see where you are going?"; walking into hydrants, stumbling over baby carriages, passing by a patient or friend who may be right beside you on the street—yes, even if your mind wants to, you are not allowed to forget for a moment the peril of impending and ensnaring blindness that hovers over you.

There must be many like me—the unknown, unreported legally blind, and near blind, who silently work and wait in secrecy—fearful of detection which would jeopardize their income, and yet more fearful of the day when total irretrievable loss of sight will crush them into an abyss of dependency, hopelessness and almost complete uselessness. Yes, theirs is a life of fear and dread; the hope they could muster with the knowledge that secience is actively and unsparingly at work is even denied them as they become aware of the shocking inadequacy and disorganization in the field of ophthalmological research.

The unsolved problems in the field of eye diseases are many. The specialty of ophthalmology is young, and the ground is fertile for pioneering effort. The unexplored areas and new frontiers of professional knowledge are awaiting the initiative and genius of the modern miracle men of science. Those who wish to delve into these unknown fields for the benefit of you and me and mankind should be encouraged with the assurance of adequate financial support, proper facilities and equipment.

Since private funds for research in this problem are so scant, and since research in ophthalmology is so woefully inadequate, and as blindness creates a drain of many millions annually on the Federal Government in relief to the stricken blind, I feel that for the benefit of the Government, as well as for the welfare of its component citizenship, that adequate funds be allocated to create a national center for research into eye diseases, and that the Government in cooperation with private agencies establish as many research projects as feasible throughout the country in leading hospitals and universities.

Only in this manner can this so-long-neglected stepchild in the medical research field attain its proper status, and contribute its share to the health and welfare of the Nation.

Mr. Chairman, I merely want to include in the record another statement from Mr. John H. Kuck, in the interest of saving time. He is not appearing here as a witness. He is in the applied physics laboratory of the Johns Hopkins University and pretty much in the same situation as the statement just read.

Mr. PRIEST. Without objection, Mr. Kuck's statement will be included in the record in full.

Miss WIESENFELD. Thank you.

(The statement referred to is as follows:)

QUALIFICATION OF WITNESS (FOR HEARINGS ON OMNIBUS BILL, H. R. 3943)

Mr. Chairman and members of the committee, my name is John H. Kuck.

My educational background consists of a masters degree in electrical engineering from the Illinois Institute of Technology.

My position is research engineer for the applied physics laboratory of the Johns Hopkins University which operates under a contract with the Navy Bureau of Ordnance.

I was awarded the Army-Navy Certificate of Appreciation for my work with this laboratory during the war.

Since I have been afflicted since childhood with an eye disease known as retinitis pigmentosa, for which doctors have told me there is no known remedy and which may eventually lead to total blindness, I have a personal interest in any program which may stimulate ophthalmological research. My own observations have convinced me that there is a great need for increased emphasis on medical research in this field. Therefore, I am vitally interested in the recommendation, which is being sponsored by the National Council to Combat Blindness, that a National Institute for Ophthalmology be established.

If I may be permitted to relate a few of my personal experiences, I believe that these may help you to appreciate some of the physical and psychological problems which are frequently associated with diseases of the eye. Therefore, I should like to submit the attached statement for the record and to express my appreciation for having been granted the opportunity to do so.

I would also like to make an oral summary of my written statement, if I may have your permission to do so.

STATEMENT SUBMITTED BY JOHN H. KUCK

Many of you may be unfamiliar with the eye disease known as retinitis pigmentosa. Its symptoms in the initial stages are a gradual narrowing of the field of vision accompanied by night blindness and a decrease in the ability of the eye to adapt itself quickly to changes of light intensity, such as occur when one goes into a dimly lighted room from out of doors.

In my own case the condition is not yet serious enough to prevent me from earning a living and leading a fairly normal life. My field of vision is approximately 9 degrees. This means that if I were standing 5 feet from the wall of a room, I could see at one instant only as much of the wall as would be included in a circle 1 foot in diameter drawn upon it, whereas the normal person could take in the whole wall at a glance. All sorts of things might be occurring outside of the 1-foot circle which I happen to be looking at, and I would be oblivious to them.

This can lead to all sorts of unusual incidents, which are often ludicrous and sometimes painful. For instance, a person who extends his hand to shake hands with me may wonder why his hand is left dangling in midair, as it is likely to be if I do not happen to notice it.

The symptoms of the disease in its initial stages are probably more difficult for children to bear than adults, since they do not know why they stumble, bump into people, cannot find things quickly, and are unable to compete successfully with other children in the physical sports. It would be strange if a child did not become shy and maladjusted as a result of such experiences.

An adult can at least know the explanation for his difficulties and proceed to adjust himself to them on a rational basis. One of the things he must learn is to proceed more slowly than normal people when moving through crowds or in confusing situations, so that he will have time to move his eyes from side to side and scan the whole scene in front of him frequently enough to obtain the information necessary to keep out of trouble. Once in a while he has to be forcefully reminded of this fact I recall an incident which happened not too long ago, when I succumbed to the temptation to run for a bus. Since I had my visual beam fixed on the bus, I failed to notice a garage attendant pulling a hose across my path. As a result, I came to a sudden unhappy landing on the pavement in a puddle of oil.

A person with a narrow field of vision will probably refrain from many activities which he ought or would like to participate in for fear of appearing ridiculous or of calling attention to his difficulties. He may even refrain from making friends for fear that they may lead him into confusing situations or because it is easier for him to walk alone in a crowd at his own slow pace.

But as long as there is some vision left in the central field, he may with perseverance master his difficulties and learn to keep out of trouble most of the time. Nevertheless, there is always in his mind the fear of the future, with the burning question of how long it will be before the central field disappears. The doctors do not know the answer to this question.

Another question involving even more mental torture is whether or not one should have children, since this disease shows signs of being hereditary. A person first decides that he will not have any children. Later on he will probably weaken in his resolve. And then, when a child does come, the parents will be plagued by the worry that the son or daughter may have to grow up to face the same dismal fate. Since I have a son of my own, who is just 3 months old, I can assure you that such problems are real in the mind.

If the things I have told you were just my own personal problems, I realize that they would not be important enough to warrant the attention of this committee. But I am sure that they are typical of the experiences of thousands of other people with eye difficulties. Some persons I have talked to who have the same disease as I have in more acute form have told me of many experiences which were much more tragic or hair-raising than any of mine. These people, who live in the strange world halfway between the sighted and the blind, cannot expect the sympathy that a blind person receives, because their condition is not obvious to the casual observer and they are reluctant to reveal it. They are likely to be blamed, instead, for the unavoidable blunders which they commit. Nevertheless, they want desperately to hang on to any last shreds of vision that remain.

If my words are not sufficient to bring home to you the full import of the social and economic losses that result from the conditions I have described, then I can at least serve as an example of a person whose service to the Government in the form of scientific research for the national defense can be prematurely terminated whenever the disease which I have described progresses to its normal conclusion.

Mr. PRIEST. Are there any further questions? Miss Wiesenfeld, again we appreciate your very fine statement and your appearance before this subcommittee.

Miss WIESENFELD. Thank you, Mr. Chairman. It has been a pleasure to be here, and while I am here, I merely want to say while I started this National Council to Combat Blindness, because of the serious deficiency in the work and I want to preserve the little sight that I have and although it may seem unimportant to others, it is terribly important to me.

Ever since I have been in this work, each day, as I meet more people in this predicament, I realize that this work is essential, that it must go on, and that our Government can certainly help tremendously in the effort.

Thank you very much.

Mr. Priest. We are sure that you have given some very valuable contributions to the cause of it also.

Mr. Priest. Our next witness will be Dr. V. Everett Kinsey.

The Chair is mindful of the fact that Dr. Kinsey is quite a modest man. The Chair is also mindful of the fact that he has an international reputation in this field and this subcommittee feels most fortunate in having a man who is regarded throughout the world for his achievements in this field, such as Dr. Kinsey, appear before the committee. You may proceed, Doctor.

STATEMENT OF DR. V. EVERETT KINSEY, PH. D., HOWE LABORATORY OF OPHTHALMOLOGY, HARVARD MEDICAL SCHOOL, BOSTON, MASS.

Dr. Kinsey. Thank you, Mr. Chairman, for those very kind remarks.

My name is V. Everett Kinsey. I hold a doctor of philosophy degree. My position is assistant professor of ophthalmic research, Howe Laboratory of Ophthalmology, Harvard Medical School, and director of special eye research on retrolental fibroplasia, Massachusetts Eye and Ear Infirmary, Boston, Mass.

I think I can speak unofficially for the only national research association in opthalmology in the country. That is the Association for Research in Ophthalmology.

My duties are: 1. To perform and direct research on problems relating to the eye. 2. To teach physiology and biochemistry of the eye to physicians who will become ophthalmologists. 3. To train persons in ophthalmic research.

I am a member of the Association for Research in Ophthalmology, an honorary member of the New England Ophthalmological Society, and a member of the American Chemical Society.

It is unnecessary with this committee to stress the worthiness of any program designed to alleviate blindness. Previous witnesses have presented statistical studies of the number of persons who are blind or whose vision is seriously defective. They have pointed to the personal and economical losses involved. It is my purpose to show that significant reduction in the blind population, or in the number of persons who will become blind in the future, cannot be expected to result from the present research in ophthalmology.

The number of persons who are conducting research in blinding eye diseases is small indeed. Let me illustrate with one disease, glaucoma. This is caused by excessive pressure in the eye which, if untreated, results in blindness by pressure on the optic nerve. There are approximately 30,000 persons blind from glaucoma in the United States. How many workers do you suppose, gentlemen, are presently devoting full time to research on this particular disease? A generous estimate is three.[1] Actually, there are less than 20 full-time research workers in the whole field of ophthalmology. While there are perhaps as many as 100 practicing ophthalmologists who spend a part of their time in carrying out research, their studies are of necessity of a sporadic nature. Their investigations frequently represent clinical testing more than development of fundamental principles on which new therapy might be based. The work of these ophthalmologists is seriously handicapped by lack of laboratory facilities and consulting personnel.

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[1] The figures presented are based on a personal survey extending from coast to coast, and I believe are conservative. The details of this survey were published in Science (Fundamental Research in the Clinical Specialties, Science 105: 373 (1947)), copies of which have been given to the chairman of the committee.

The explanation for the paucity of research effort aimed at preventing blindness is primarily lack of financial support. There are in the United States only four or five laboratories (Harvard, Columbia, Johns Hopkins, the University of Iowa, and the University of California) which have sufficient funds to employ to full-time research investigator or research staff in ophthalmology. Rising costs and the general tendency of private foundations to curtail grants-in-aid have reduced the personnel even in these laboratories.

As a director of research work, gentlemen, I now spend more than one-quarter of my time not in the laboratory but out trying to raise funds to carry on our research work.

The need for expanded research on blinding eye diseases is apparent. The question which confronts us is whether it would or would not be profitable.

I would like to give two illustrations of our lack of knowledge in ophthalmology, the correction of which should result from additional research and which should certainly be of practical importance in establishing better therapy.

A friend of mine who had a detached retina, a relatively common eye disease, asked me to explain to him why the retina became detached. I said, "I cannot explain it. We do not know why it is held on in the first place."

The second instance is in connection with this glaucoma disease, which is a high pressure in the eye. Gentlemen, we do not know what maintains the normal pressure in the eye, much less why it increases to injurious heights.

In the two diseases cited we are so lacking in basic knowledge that it is extremely difficult to know what to do when the diseases develop.

I should like to mention another instance: There is a new disease called retrolental fibroplasia about which you will hear more this morning. You have probably read in the newspapers about the Hoffman twins of New Orleans who have retrolental fibroplasia and who were recently flown to New York City. Retrolental fibroplasia is the name given to the disease in which a membrane forms behind the lens about a month after birth. The membrane shuts off the light which can get back of the retina. The disease is associated with premature infants and has been increasing in frequency relatively enormously in the last 10 years. In this particular case I know of two studies which are being carried out at the moment which, if one is successful, will simply eradicate the disease and thus prevent this large number of babies from being blind for life.

The answer, in my opinion, to the question of whether research in ophthalmology would be fruitful is an emphatic "Yes."

We must be less optimistic for those already blind. There are certain cases where blindness can be prevented, we know now, and there probably will be more.

The great hope definitely lies in preventing blindness so that 20,000 additional people will not be added each year to our blind population.

The second question is: How can research in ophthalmology be expanded best? In the writer's opinion, this can be accomplished by long-term grants-in-aid, first, to those institutions having facilities and a past record of accomplishment in ophthalmic research; and, secondly, to such other institutions which may be specially qualified for such research.

In a clinical specialty such as ophthalmology, it is absolutely essential, both for teaching and research purposes, that (1) research be carried out in proximity to large numbers of patients (for example, in teaching hospitals and large centers of population); and (2) grants, of any size, should be extended over a period of 5 to 10 years to attract and keep good scientific and medical personnel.

I can definitely say, from my own experience, you cannot hire a good basic scientist if you offer him a 1-year fellowship. That is all right for training purposes. By the time he becomes a really capable man as a research scientist, very often he will go off to teach chemistry or go into the practice of medicine if you cannot offer him some hope that he will have a relatively permanent tenure. The importance of tenure, therefore, cannot be overemphasized. No amount of funds can insure success of research in the absence of continuity of effort.

I therefore respectfully recommend to this committee that steps be taken to provide funds for research on the causes, treatment, and cures of blinding eye diseases, in the manner outlined above.

Mr. PRIEST. Doctor, we appreciate your statement. It is your opinion, I gather, that whether we should pass the omnibus research bill (3943) with amendments, or just as it is, or whether we should pass Mr. Biemiller's bill, or title II of the omnibus bill, it is your opinion that the greatest progress can be made in this field by emphasis on grants-in-aid to institutions already doing this type of research. Is that your opinion?

Dr. KINSEY. Yes.

One further point: I know, from my experience, that you cannot at this moment hire 10 people to do research in ophthalmology, because they do not exist. It would be much better, I think, Mr. Chairman, and I think much more efficient, to spend any money for ophthalmic research in places where research is already being performed, and using these places as training centers.

If a research institution is built eventually, positions can then be obtained from centers which are now in existence.

Mr. PRIEST. And, under the regular institute program that is now in effect in connection, we will say, with the mental health, heart, and cancer, there is in connection with those programs a grant-in-aid program.

Dr. KINSEY. Yes.

Mr. PRIEST. That seems to have worked very successfully so far?

Dr. KINSEY. Yes, sir.

Mr. PRIEST. Are there any other questions?

Mr. BIEMILLER. Yes, Mr. Chairman. These bills and this bill provide for grants-in-aid for this type of work?

Mr. PRIEST. Yes, both bills do. This does in title II, 4312 and 4313, and the other related bills.

Mr. Biemiller. I think, as the chairman remarked briefly a moment ago, that in general the institutes have followed a pattern which is pretty well understood. Grants-in-aid have been made, and also they do research work in their own institutions, but there is no hard and set pattern they can operate under within the program. It is left to the discretion of those attempting to carry on the work.

Mr. Priest. In this particular bill, the emphasis, for the time being at least, you think, could more profitably be placed on the grants-in-aid program?

Dr. Kinsey. Yes, sir.

Mr. Priest. I have one further question, Doctor. Reference has been made by earlier witnesses before the committee this morning to the prevailing attitude in the past, at least, of hopelessness in the field of research, for blindness and defective vision.

You feel, I gather from your statement, that with proper research there is no basis for a hopeless attitude?

Dr. Kinsey. I certainly agree with that. There is no basis for a hopeless attitude. If I did not agree with that, I would hardly be spending all of my efforts and time in working in this particular field.

Mr. Priest. I think that is a very good statement. Are there any other questions?

Mr. Biemiller. Dr. Kinsey, you made some reference to the fact that you spent a certain percentage of your time in the effort to raise funds. I take it that your experience, then, substantiates the statement of other witnesses that funds for basic research in this field have been very small in amount and that you are still having difficulty raising them, because people do not realize the need for basic research in this field.

Dr. Kinsey. That is correct.

Mr. Biemiller. Do you think that more people think of the care of the blind rather than research intended to discover remedies and cures?

Dr. Kinsey. It has always been my opinion that, if we could have 5 percent of the amount that is spent in rehabilitation for research, their loads in the course of time would be decreased by a great deal more than 5 percent, not to mention the alleviation of the suffering from blindness and so on.

Mr. Biemiller. You also share the view that one witness expressed here earlier; that, if the Government were to grant funds to start an intensive research program, that might center attention on the problem and result in voluntary funods being raised for this work?

Dr. Kinsey. I think it would, Mr. Biemiller.

Mr. Sadowski. How successful have your fund-raising campaigns been?

Dr. Kinsey. Well, I can be specific. If by October 1, 1950, I do not have $30,000 a year, the whole research in retrolental fibroplasia will have to be abandoned.

Answering your question more specifically, the efforts have been relatively successful. By virtue of one chance or another and a good deal of effort, we have enough funds at the moment, but now I have to go out of the laboratory, where I think I belong, and start worrying about what happens after a certain deadline. That is a continuous problem.

Mr. SADOWSKI. What is the minimum amount that should be furnished either by the Federal Government or other agencies of Government or by private people in order to give at least the minimum amount of support to this research program that is required?

Dr. KINSEY. I have had the feeling for a long time that there is certain optimum about a laboratory budget in this field. The optimum in one of these laboratories in a teaching institution, in my opinion, would be somewhere between $50,000 and $100,000 a year. It is my suggestion that at the moment there should be perhaps six or seven such laboratories.

It is not possible to date to set up 30 or 40 even if we wanted to and had all of the funds in the world. The trained people simply do not exist in this field, and that is why I think we should have grants-in-aid to the institutions that are doing this research. A budget of that sort would amount to about $500,000 a year.

Mr. SADOWSKI. In other words, about half a million dollars.

Dr. KINSEY. A year.

Mr. SADOWSKI. That would cover it?

Dr. KINSEY. But, again, I would like to emphasize that we can get nowhere at all if we had half a million dollars this year, unless we could have the assurance that we were going to have half a million dollars next year and the next.

Mr. SADOWSKI. You are one of the most modest men who has ever come here asking for money.

Dr. KINSEY. I am also faced with the responsibility of spending money; and, gentlemen, that is very difficult, as you well know.

Mr. WILSON. Mr. Chairman.

Mr. PRIEST. Mr. Wilson.

Mr. WILSON. Dr. Kinsey, as you read your statement, I note, on page 2 of your statement, that this follows up what my colleagues here on the committee have been talking to you generally about; but that portion of your statement I have reference to reads thus:

> Rising costs and the general tendency of private foundations to curtail grants-in-aid have reduced the personnel even in these laboratories.

And you digressed from your prepared statement to say that you spent, as Mr. Biemiller stated, a considerable amount of your time—I believe you said one-fourth.

Dr. KINSEY. That is correct.

Mr. WILSON. In raising money.

Dr. KINSEY. Yes, sir.

Mr. WILSON. Now, you have had a great deal of experience in connection with that. I believe it would be helpful, at least to my mind, and I have been thinking along this line for a long time, if you could tell us why it is that that tendency has been going down among our people to devote their private funds to these purposes.

Dr. KINSEY. I can answer that. I am very happy that you brought the question up. It is so good that it looks like it was planted.

Mr. WILSON. It certainly was not a planted question. I have asked previous witnesses the same question a good many times.

Dr. KINSEY. As an illustration, I will refer to the John and Mary Markle Foundation, which I believe had a capital fund of over $19,000,000. They, for a good many years, were giving grants-in-aid for research to aid various medical-research programs; they gave more money for research in ophthalmology than any other single private agency.

The Markle Foundation changed their policy 2 years ago and decided that these small short-term grants-in-aid for medical research did not accomplish the purposes for which they were intended. For about 2 years they did nothing while they looked into what to do next. What they finally did was to make a 5-year grant, to one individual, who could select his own research field. I think this is the tendency also—I am not sure of this—of the Rockefeller Foundation.

It is necessary to have a firm foundation, a continuity of effort. Does that answer your question?

Mr. WILSON. That answers it in part. There must be some other reasons, not only as to research but as to other health programs in the Nation, as to why the tendency is going down all of the time as to contributing voluntary private funds.

Dr. KINSEY. It is my guess that there have been more funds than ever given by the public in recent years to health programs, chiefly by virtue of these special campaigns; one must not forget that the private foundations have had their interest rates cut progressively as you know over the course of time, and that the cost of doing research, like the cost of everything else, has doubled. These two factors would result in an over-all diminution of efforts.

Mr. WILSON. I think that is very true. Now, Doctor, I want to ask about another thing .

You digressed from your statement at the end to talk about this third type of case where something forms back of the lens in the case of infants born prematurely, particularly.

I believe Mr. Walker, yesterday, in his testimony, spoke of that and said that was true of about 12 percent of all of the premature births.

Dr. KINSEY. Yes; in a Boston hospital it is 25 percent of all babies born weighing less than 4 pounds. The problem has been so serious, gentlemen, that the question sometimes arises in a number of people's minds as to whether or not we should try to save all the prematures. We hope that through research the problem of retralental fibroplasis can be eliminated entirely.

Mr. WILSON. I believe you said that there were two projects or researches going on now that would be quite helpful along that line.

Dr. KINSEY. Yes; we have one, and there is one at Johns Hopkins.

Mr. WILSON. Thank you.

Mr. SADOWSKI. Is Johns Hopkins today the largest and best-equipped institution for this kind of research work?

Dr. KINSEY. Sir, that is a hard question to answer. Let me say their work is extremely good. I think right now that the number of full-time people engaged in research work is less at Hopkins than we have. During the time that they had the John and Mary Markle funds, I think that they were the larger. If you were to ask me about the quality of work, I would say that they have the outstanding research man in ophthalmology at Johns Hopkins in the world today.

Mr. SADOWSKI. What institution has the most money for research?

Dr. KINSEY. I think Johns Hopkins has more money, but their budget is complex. Their director, with whom I spoke last week at

Atlantic City, in discussing his budget, said it was very difficult even for him to determine just how much money they spent for research and how much money for clinical work as the fiscal separation is not clear cut.

Mr. **Priest**. Are there any further questions?

Mr. **Biemiller**. Do you know of any other institution which has evidenced a desire to start research in this field, which is handicapped because of funds?

Dr. **Kinsey**. Yes; Ohio State University; Columbus is trying to start one. There are also two on the west coast—one, the University of California and one at Los Angeles.

The University of Pennsylvania has evinced a considerable amount of interest and has a research program planned. There are probably others in the country which are ready if they had the necessary funds.

Mr. **Sadowski**. Over and above the question of funds is the question of available research personnel; is that not true?

Dr. **Kinsey**. Yes, sir.

Mr. **Sadowski**. But, as a generalization, over and above the research institutes, there are then a few other spots which might be interested if funds were available, and would show an immediate interest?

Dr. **Kinsey**. That is correct, sir.

Mr. **Priest**. Are there any further questions?

Mr. **Wilson**. Doctor, would there be people that might man and staff such centers should, for instance, the University of Minnesota and the University of Oklahoma start, and are there funds available and are there people which would be available in the future or near future?

Dr. **Kinsey**. I would say that it would take 2 or 3 years to make even a good beginning. I am not conservative in this estimate. It again illustrates the present lack of research in this field of blinding eye diseases.

Mr. **Wilson**. You must emphasize the point that the tenure of aid for the people that are going to staff these must be made not just shortsighted but for a long time.

Dr. **Kinsey**. That is right; it is absolutely essential. One cannot expect progress in research by merely hiring a half-dozen chemists; they must be trained in ophthalmology. The ophthalmologist in turn has to be trained in research methods. In either case it takes a period of years.

Mr. **Wilson**. Thank you.

Mr. **Priest**. If there are no further questions, Doctor, we certainly thank you.

I notice that Mr. Adelsheim was rising perhaps to ask a question?

Mr. **Adelsheim**. I just wanted to add one word to Mr. Biemiller's question; it takes 13 years for a doctor to become a recognized ophthalmologist. At that time he is in his early thirties and unless he has an opportunity to go into a research institute he must immediately start practicing in order to earn a livelihood and that is one of the problems and reasons why we do not have research ophthalmologists today.

Mr. **Priest**. Thank you, very much.

Now we will hear from Dr. Daniel A. Poling.

STATEMENT OF DR. DANIEL A. POLING, CHAIRMAN, NATIONAL COUNCIL TO COMBAT BLINDNESS, INC., CHRISTIAN HERALD ASSOCIATION, NEW YORK, N. Y.

Dr. POLING. Thank you very much, sir.

I want to apologize to the chairman and the committee. I was in the air over Washington for over an hour before I could get down.

Mr. PRIEST. You may proceed, Dr. Poling.

Dr. POLING. My name is Daniel A. Poling. I am editor of Christian Herald and president of the World's Christian Endeavor Union.

There is for me in this hearing, sir, a great poignancy because the mother of my eight children suffers from glaucoma and she is fighting one of those heroic battles. After 18 months, as a result of the research and new discoveries, we were able to hold what sight she had left so that this session goes to the heart of a very vital matter, goes right into my heart as it does into the hearts of many American citizens.

I am chaplain of the Chapel of Four Chaplains, an interfaith shrine and memorial to the four young clergymen of three faiths who went down on the steamship *Dorchester* when she was sunk by enemy action in the North Atlantic. Presently I serve as a member of the President's Committee on Religion and Welfare in the Armed Forces, and have just returned from a 29,000-mile journey to Tokyo, the Philippines, Korea, Alaska, and the islands of the Pacific in connection with a special mission for this committee.

My business address is Christian Herald House, 27 East Thirty-ninth Street, New York 16, N. Y.

Sometime in 1946 I met Mildred Wiesenfeld, founder and now executive director of the National Council to Combat Blindness. Through conversations and correspondence with her during which I studied pertinent facts as to the importance of the undertaking she and her group had set out to accomplish, I became aware of the overwhelming need for funds in order to carry on more adequate eye research. I agreed to help this organization and program and assumed the organizing chairmanship. Through this campaign a group of nationally known men and women in nearly every walk of life joined me.

Since 1947 I have served as honorary chairman of the National Council to Combat Blindness and have been in close touch with its work and problems. I therefore am happy to be here today and to add my voice to those of the other witnesses. It is my earnest hope that Government aid will be granted so that a national institute for eye research may be established.

With your permission, Mr. Chairman and members of the committee, I submit the attached statement for the record.

(The statement referred to is as follows:)

Of all the human ills to which mortals are heir, none is so trying and desperate as the tragedy of blindness—blindness whch strikes young and old, rich and poor, all races, all creeds, and destroys so much of the usefulness and independence of the individual.

Recently, in my newspaper column, I wrote of a man who, through a natural miracle—what appeared to be almost a direct act of God—regained some of his sight after years of apparently hopeless darkness. Instances such as this are so rare that their occurrence merits special notice in the press and on the radio. However, we must not sit back and wait for such miracles—hope and prayer alone are not enough, as witness the 260,000 blind in this country and the additional thousands faced with impending blindness. In most cases of fading vision, doctors must sit helplessly by, for science has not yet forged sufficient weapons of knowledge.

To give essence to the faith and prayer of the countless eye sufferers, the quest for comprehensive research into the many blinding eye diseases must be intensified. I am told that only approximately $400,000 is spent annually in this very rich country of ours for eye research. This pitifully inadequate sum represents the total expenditure of both Government and private funds. The mysteries of eye health and disease cannot be even seriously approached with so meager an outlay.

Only through adequate financial and sponsored research can the many eye problems begin to be adequately studied and eventually solved. If $38,000,000 can be spent in a single year by the Government for welfare relief to the stricken blind, is it not economically wise to invest in a program of research aimed to attack the scourge of blindness at its source and to minimize future Government responsibilities to those yet to be stricken? Public acceptanbe of apparent hopelessness of blindness has been evidenced by generous contributions to rehabilitation programs, but practically none to research.

The National Council to Combat Blindness, of which I am honorary chairman, has set out to educate the public to the wide need for research, and to enlist its support for this purpose.

It has been a heartrending experience for me to witness during the past 3 years of this organization, the pressing and tragic need for eye research and the understandable inability of a new, single organization to meet its share of this need. Financial aid from the Government is imperatively required to accelerate this newly initiated program and it is only through a combination of public and private agencies with public support that this can be done.

Since most eye difficulties begin after the age of 40, with our increased life span, the incidence of blindness is on the upswing. Prompt attention should be given to this growing problem before it assumes even more serious proportions.

I shall not burden you with statistics, which I am certain are being supplied in the testimony of others. My only request is that you carefully consider the facts presented. I believe that such consideration leads to but one conclusion—the imperative need of funds for research into eye diseases and the worthy role of the Federal Government in this program. Funds invested now in study will not only be of economic gain to the Government in future smaller costs for welfare aid and rehabiltation of the blind, but will alleviate human grief and sorrow—that gloom of deep darkness that cannot be dispelled by all the financial aid in the world.

As a clergyman and editor I have sought to assist those movements that seek with sacrificial service to relieve human suffering. In appealing to you on behalf of the establishment of a national agency for eye research, I believe that I raise my voice for one of the most vital and timely of all the movements that have engaged my attention and deep concern.

Particularly I commend to you Mildred Wiesenfeld, executive director and founder of the National Council to Combat Blindness, one of the most inspired and selfless persons I have ever known.

Mr. PRIEST. I feel sure, Dr. Poling, that the committee having had the opportunity of having Miss Wiesenfeld before it, shares your respect. We appreciate your appearance before this committee, the zeal and enthusiasm that you have put into this campaign.

Are there any questions of Dr. Poling?

Mr. SADOWSKI. No questions.

Mr. PRIEST. Mr. Bennett?

Mr. BENNETT. No questions.

Mr. PRIEST. Mr. Wilson?

Mr. WILSON. Mr. Chairman, I feel that this committee has been highly honored to have such an outstanding gentleman as Dr. Poling appear before it.

Dr. POLING. Thank you, gentlemen.

You have highly honored me by giving me the opportunity to come and speak on this issue.

Mr. Priest. Gentlemen, we have Mr. Albert Hirshberg, who is a sports editor for a great paper, the Boston Post. As a former sports editor, the chairman is glad to welcome Mr. Hirshberg.

STATEMENT OF ALBERT S. HIRSHBERG, APPEARING ON BEHALF OF A PARENT GROUP, BROOKLINE, MASS.

Mr. Hirshberg. Mr. Chairman, I might say that I am merely on the sports staff and not the editor.

My name is Albert S. Hirshberg. I am an author and magazine writer on sports subjects, and a member of the sports staff of the Boston Post.

I am the father of a blind baby boy, aged 21 months. He has retrolental fibroplasia, a newly discovered eye condition which seems to be associated with excessively low weight and prematurity at birth. My child has been examined by the foremost ophthalmologists in Boston, all of whom agree that there is no known cure for him. Only research may find the answer to his possible cure and to prevent others from becoming blind from the same disease.

I am here representing not only my own child, but 150 other children 4 years old or younger, all of whom also suffer from retrolental fibroplasia, and all of whom are also located in the environs of greater Boston. There are about 300 cases of the condition within a radius of 50 miles of Boston. I also have knowledge of some 400 cases in the New York area, over 100 in Chicago, 50 in Pittsburgh, and many more in other sections of the country.

It is my understanding that medical science has no known method of preventing retrolental fibroplasia. From my own experience, I know that it has increased in frequency in New England. The parents' group which I represent has been doubled in the past year, and there are new members at each succeeding meeting. In each case, parents are told by qualified opthalmologists that there is no hope for sight in their children.

As formally elected representative of the Boston group of parents of children blind from rentrolental fibroplasia, I respectfully ask that some provision be made in the omnibus research bill to furnish funds to institutions studying this and other blinding eye diseases.

Mr. Priest. Mr. Hirshberg, we appreciate your statement. You feel that it is important that whatever bill we pass or may pass that adequate funds be provided for research in this field?

Mr. Hirshberg. I do.

Mr. Priest. Any questions, gentlemen?

Mr. Sadowski. No questions.

Mr. Priest. We thank you so much for your appearance before the committee.

Mr. Hirshberg. Thank you.

Mr. Priest. Our next witness this morning will be Mr. J. M. Ulmer, attorney, of Cleveland, Ohio. You may proceed, sir.

STATEMENT OF J. M. ULMER, ATTORNEY, CLEVELAND, OHIO

Mr. Ulmer. Mr. Chairman and members of the committee, my name is J. M. Ulmer. I am a lawyer in active practice in Cleveland, Ohio, and my address is 1130 B. F. Keith Building, Cleveland, Ohio.

I am endeavoring to stimulate fundamental research to find the causes, the prevention, and the cure of blinding eye diseases.

For more than 2 years I have devoted my interest to this cause. I have studied the question, have talked to professional and laymen, have had correspondence with ophthalmologists, universities, scientists, staff members of research laboratories and clinicians, and by personal contact, by mail, and by intensive reading, have assembled a great deal of data. I have done this as a volunteer, with the hope that, with others, plans may be developed and funds may be found to meet a situation which requires correction.

With your permission, may I present the attached statement for the record. I appreciate the opportunity of laying before you pertinent facts which I trust will help you in your consideration of the legislation now pending before your committee.

Should time permit and with your permission, I shall be pleased to further discuss this matter with the committee.

I shall proceed to read the statement if it meets with your approval.

Mr. **Priest.** Very well, sir.

Mr. **Ulmer.** For a period of 22 months I could not read a line. During my long period of incapacity and after my sight was restored 2 years ago by a competent surgeon after a cataract operation, I studied the matters I shall discuss in this statement. I appear here and wherever I may be heard to help in a cause too long forgotten. I believe it is high time that consideration be given and something constructive be done to attract the attention of all interested in bringing about proper fundamental and clinical research in order that the causes, the prevention, and the cure of blinding eye diseases may have the consideration of all who value sight.

I am not a paid advocate. When my sight was restored, I determined that I would, by serving in my own limited way a long-neglected cause, indicate my appreciation in part for the restoration of my sight. I bring to your attention the results of the protracted study so made on what is, or, rather, what is not being done with respect to research on the diseases of the eye leading to blindness.

The statements herein made are predicated upon intensive study for the past 2 years, including personal, and by correspondence, contact with many leaders in the field of ophthalmology—scientists, universities, governmental agencies, and so forth. Some of the sources of information are set forth on exhibit 1, attached to this statement.

When sight runs out you turn to medical science. You ask:

What causes the impairment of sight?

What can you do to regain your sight?

What is fundamental research in the eye field?

Is there a lack of teamwork between clinician and scientist in basic research in the blinding diseases?

Is there a need for fundamental research in the eye field?

How can fundamental research for the causes, the prevention, and the cure of blinding eye diseases be secured?

In your study you find that thousands have impaired sight or are totally blind. You find that there are but a very few outstanding eye-research laboratories, that in this country there are literally less than 20 men engaged full time in research studies designed to determine the causes of diseases leading to blindness and to provide new forms of therapy. You find that in more than 75 percent of the blinding-eye diseases you are literally against a stone wall. You are faced with a future of darkness.

As you read the studies made on the blinding eye diseases time and again you find the phrase "unknown to science," "undetermined by physician," or "not specified." In the book on The Causes of Blindness issued by the Federal Security Agency, you find statements such as this:

> Little is definitely known of the underlying causes of diseases such as glaucoma, atrophy of the optic nerve, cataract—

All of which is summed up by the statement based on the authority of the Federal Security Agency in its last study of the subject of blindness in the following language:

> Since the underlying causes of many eye defects are still obscure, a large proportion of cases is indicated under the heading "Unknown to science."

I might say that this publication is the last word on the subject which the Federal Government has put out and I call it the Blue Book—very interesting reading.

For lack of research there is no answer to the question, "What can you do to regain your sight, or to prevent the loss of it, or to cure the diseases that caused you to lose your sight?"

You find that there are meager dollars available to the few outstanding eye-research centers in this country. Without money they cannot function properly. These few splendid eye-research laboratories such as Howe at Boston, Wilmer at Johns Hopkins, the department of ophthalmology of the University of Pennsylvania, and a few other similar laboratories such as the Institute for Vision at Ohio State University recently founded can, if properly supported and expanded, help find the answer to the problem of what to do to find the causes to cure and prevent blindness. In these laboratories you have the beginning of the pattern of fundamental research in the blinding eye diseases.

Generally you find that the field of research to discover the causes, the cure, and prevention of blinding diseases is unplowed. You are frustrated when you make the inquiry and find the answer to the question that you have put to be "I don't know" or "unknown to science." You are challenged by these facts; at least I was.

You are faced by the harsh fact that the subject of fundamental ophthalmological research except in a few places has been lost in the study of diseases. Why so little attention has been paid to so necessary a function of life as one's eyes passes understanding. We must change these conditions. In this country of ours we find that scant dollars have been made available to find the answer to blinding eye diseases. I must repeat that where the few qualified research groups are found all—I cannot make that emphasis too strong—need money in order to expand their activities and enlarge fundamental research so that the causes, the cure, and prevention of blindness may be found. This statement I make ureservedly. I have written evidence from all over this great land to prove that eye research has not been made for lack of money.

As the human life span is lengthened more and more pople find their sight impaired or destroyed. New classes of blindness have been developed in the birth of children prematurely born. A good authority states that there are probably 800,000 persons with unrecognized glaucoma, a dread disease, leading many to blindness, if not detected.

Yet, for lack of plan and lack of dollars, science has not been able to find what causes many of these conditions and what to do to correct the same. Competent authority says that there are not three or four full-time men in the entire country devoting their search for the answer to the questions, Why glaucoma? How can it be prevented?

You find that governmental agencies alone spend more than $35,000,000 each year to help those who are already blind, yet only about $400,000 per year is spent in research to prevent blindness. Of this, we are advised, the Federal Government spent less than $80,000 last year in grants for research in eye diseases. I have proof of that statement dated no later than the 10th of June 1949 from the Government.

Others have and will supply further statistics, statements, and general information which will fill out and amplify the sketchy statements made herein. This information should prompt your earnest consideration of a situation which demands that the Congress should provide the machinery and supply the money so that through fundamental research, the causes, the cure, and the prevention of blindness may be brought about.

Too long has this field been neglected. The preservation and the restoration of sight and the prevention of blindness through medical research by discovering its causes is so fundamental and simple a concept that one need not labor the point. The time has come when something should be done to remedy this deplorable and long-neglected problem.

Only through the Federal Government and especially under legislation providing for support of research under the Public Health Service Act and, especially **H. R.** 5046, now under consideration, can the way be found and the money provided to meet this situation?

I would not presume to tell this committee what the form of the legislation should be. I have appeared before legislative committees in my capacity as a lawyer and I know how difficult it is to draft legislation.

However, when you get through with your consideration I am certain you will present to the Congress a measure that will meet this situation.

When there has been dollar support, and a general process of education, both of which must be supported by the Federal Government, then perhaps the State governments and the public will see to it that additional financial support will be provided, not only to aid the blind after they are blinded but to help through fundamental research to attack the problem at its very roots.

In the 2 years spent in studying this subject, I have rather fully covered the field. The whole question of fundamental research in the clinical specialties is one of absorbing interest.

Everyone interested should read a book, The Furtherance of Medical Research, written by Dr. Alan Gregg, director of medical science, Rockefeller Foundation. The paper, Fundamental Research in the Clinical Specialties, prepared by Dr. V. Everett Kinsey, of Howe Laboratory of Ophthalmology, Harvard Medical School, and the Massachusetts Eye and Ear Infirmary, Boston, is important and informative reading.

I am very happy that Dr. Kinsey came and testified before this committee, because in my study I have learned and can testify that he probably is the outstanding man in clinical research in this country at least and probably one of the best informed in the entire world.

In this way there will be spelled out for you, as there was for me, the answers to the question, what is fundamental research and what should be done to bring fundamental research about in the blinding eye diseases?

The lack of conception of what fundamental research is was appalling to me. You talked to many pepole and they said they were doing research work; they thought they were but they were not. Dr. Kinsey explained that and the Howe Laboratory and Wilmer at Baltimore and the University of Pennsylvania are among the few fine groups in this field that need all the support that can be given to them.

These men are leaders in their fields and much is to be gained by reading what they have said and understanding the problem which I here in a very short statement present to you. I shall quote almost literally from the sources above referred to, as same tell in simple words some of the fundamentals which come to you in your study of the problem before us.

It is difficult and perhaps not necessary to define what is medical research. A knowledge of physics and chemistry are of primary importance in their field. Nor is medical research limited at all to the study of diseases. By no means is research confined to the possessors of the M. D. degree.

When Dr. Kinsey made his survey of the studies of fundamental research in the clinical specialties at the large universities, he found the situation to be, in general, unsatisfactory. Research programs were handicapped by inadequate funds and by the fact that neither the well-qualified department heads nor the underpaid clinical staff members were in a position to devote full time to the research programs. Dr. Kinsey calls attention to the fact that the number of investigators working in any given field is frequently pitifully small.

Glaucoma, for example, is one of the principal causes of blindness in individuals past middle age. And yet in the United States there are not more than three investigators who are devoting half or more of their time to this problem. Dr. Kinsey says that as a result of halfway measures the amount of fundamental research in the clinical fields is extremely small. He concludes that research is a full-time job if facilities and personnel are to be utilized efficiently and if the quality of the work is to compare favorably with that in other branches of science.

Dr. Gregg points out in his splendid work that research involves a critical examination of sources and ways of learning and what we describe as facts.

> Research may lead to the discovery and proof of new principles, and the breaking through the crust of already accepted doctrines and axioms. Scientific research involves and elaborates facts, relationships, and interpretations. Mere recording of observations and reading dials of complicated instruments is not research. The compiler can be ignorant of his material but the researcher cannot.

Dr. Gregg says:

> Confusion lies in mistaking the result for the cause. Research may lead to invention or invention may call for research, but invention is not research. Research in any field as a procedure consists of a sequence of activities, each of which contributes to, but cannot be substituted for, the whole process.

> Medical research is a part of medicine in the sense that it is one of the growing fringes of medicine. Medical research has left the medical profession itself somewhat behind, and at times clanishly resentful. Medical research, then, is in its youth, attentive, adaptable. It is only within recent times that universities and scientists have come to recognize that research is as important a part of the university as teaching, that the public does not understand or value medical research as much as it admires and praises it. The tragedy of every good cause is that it must accept praise in lieu of understanding and hospitality and words of welcome rather than sustenance.

Research, we must therefore agree, is the vital forerunner of all medical progress. And yet we are shocked to find that there is pitifully little research being conducted in the blinding-eye diseases in the universities and independent research institutions of this country. There has been a steady improvement of medical research done in the laboratories of commercial companies. Instances will be found of part-time work in eye research sporadically done, but this should not come under the name of fundamental research in any scientific appraisal of the term, and is quite different from the research of a full-time scientist teamed with other scientists in a properly equipped laboratory such as is found at Howe Laboratory in Boston, Johns Hopkins at Baltimore, the University of Pennsylvania at Philadelphia, and a very few others throughout the country.

Dollars must be supplied to meet the challenge. Medical research in the diseases of the eye leading to blindness requires the efforts of well-trained and zealous men who can devote their lives to the problem. These men must be trained in chemistry, physics, mathematics, anthropology, psychology, sociology, genetics, and so forth. We cannot ignore the importance of experienced, devoted, and gifted men who can carry on this research until the problems are resolved and the answers found.

Dr. Kinsey in great detail and after thorough study and a country-wide investigation, states that there is and has been, save in a few quarters, a lack of fundamental research for the very simple reason that dollars have not been allocated to meet the situation. Dr. Kinsey has pointed out that by expanding the activities of research laboratories like Howe at Boston, at Baltimore, at Philadelphia, and so forth, and by establishing other places like them, all of which can be done if the dollars are provided, you will have gone a long way to meet the problem.

In my study, I have found, upon contacting various groups interested in the blind, institutions, doctors, scientists, universities, all agree that the answer "I don't know" may be turned into "I do know" if money is supplied. Among the statements made to me are the following: "We have no information about what research may be going on." "We are in a position to carry on research in the various fields concerned with the blinding diseases providing funds are available to do so."

The head of one of the great universities says:

> We have here a number of research problems which bear directly or indirectly on the causes of blindness and which are in need of funds to support them.

The Rockefeller Foundation has said that of course there are departments of ophthalmology associated with medical schools but relatively few of them have active programs of research. Ophthalmologists and scientists familiar with the field agree that literally no funds have been available for fundamental research.

The Federal Government has said, "Our work is entirely with persons who are already blind or nearly blind."

Competent authority has said:

> It is needless to say that funds are inadequate to pursue studies like glaucoma in the intensive manner necessary.

A Federal agency has said:

> As is illustrated by the study in an unfortunately large proportion of cases of blindness, even when diagnosed by physicians skilled in diseases of the eye, the cause of the eye defect cannot be defined either by inadequacy of information available to the physician at the time of the examination or because the cause of the condition is not yet known to medical science. Causes are generally recorded as unknown to science.

Inquiry has been made of the various States which indicates that help is given to the blinded but literally no dollars are devoted to fundamental research to find the causes of blindness.

The Federal Security Agency, as late as June 1, 1949, points out that during the Government fiscal year 1948–49 a total of $70,340 was all that was allocated to research in the field of ophthalmology. What more need I say to prove the point that I have been discussing?

The Veterans' Administration has stated:

> No studies at present are under way on the primary causes of blindness.

The New York Institute for the Education of the Blind says:

> There is no single group interested in devoting its time and attention to the raising of funds to provide fundamental research required to find the causes to cure and prevent blindness.

Facts are being presented in this hearing which should prompt action. It is needless to labor the point. If money is supplied to the few outstanding eye research laboratories in the country and these groups in time are expanded according to plan, and others interested in the eye research field are supported, past experience indicates that sooner or later the problem of blinding eye diseases, in part at least, will be met.

The discoveries in eye research will certainly be pooled and the findings will be for the common good. The support for medical research by the Government, we trust, will increase, but up to the present time literally no dollars have been supplied for this purpose.

As late as November 4, 1948, the Institute of Ophthalmology, London, was opened. After more than a century, the English set up an eye research laboratory in which is coordinated all that is best in England in eye research.

With the help of the Parliament of England, there will be developed a research and teaching institute of the first magnitude which will permit Great Britain to continue as in the past in the grand part it has played in the development of ophthalmology and ophthalmological research. Notwithstanding great difficulty, much credit must be given for the enterprise and courage that prompted the establishment of a research institute of this type. The same is staffed by men able and willing to do research, supported by the Medical Research Council and coordinating general medicine and surgery as well as the fundamental and physical sciences, the experience and knowledge of hospitals and universities, which marks a new epoch in the advance of British ophthalmology.

This challenge I pass on to your committee. This Government must take the lead in this cause. You can remedy the situation which I have described by legislation of the kind that you are considering, if you include in it the much needed support for fundamental research in the blinding eye diseases.

Then men trained in chemistry, physics, psychology, physiology, mathematics, anthropology, biochemistry, sociology, genetics, including preclinical sciences, clinical specialties and other sciences, may find the answer to the problem of blinding eye diseases and so provide resources of inestimable value to the research worker in medicine.

Medical research and its inseparable companion, medical education, says Dr. Gregg, exist for the purpose of fighting disease and ignorance. He further says:

> From the study of diseases, medical research is moving forward to the study of health and the knowledge of what is essential to optimum performance and happiness.

The Government can direct certain kinds of medical research which otherwise will never be done. If the bill pending before you, which provides for an amendment of the Public Health Service Act, includes research into the causes of blinding eye diseases, and is enacted, the general purpose of the act, that is, to improve the health of the people of the United States through the conducting of research, will be furthered. The States, the universities, the foundations, the people must be shown the way by the Federal Government. There must be a plan, a purpose, and the money to meet the challenge now existing. If we do not do this, we shall deny sight to many yet unborn and refuse to cooperate in finding the causes for the cure and prevention of blinding eye diseases.

As I first indicated, I could not read for 22 months. Only one who has lost his sight is conscious of that most precious gift. Only one who has seen the light and then is forced to give up the use of his eyes can appreciate what others take for granted. Any person in this room could be stricken blind tomorrow only to find that "unknown to science" is the answer concerning the causes and the cure. The shock of this discovery becomes greater when it is revealed that practically nothing is being done and no one is working to find the answers to the blinding eye diseases because of their indifference or neglect. Rather, to be charitable, shall I say, the process of education on this subject has been sadly neglected. The remedy is in your hands.

Attached to my statement is an exhibit 1 which I would like to offer for the record.

Mr. PRIEST. Without objection, that will be done.

(The exhibit is as follows:)

EXHIBIT I

The information contained in the attached statement was obtained through voluminous correspondence, a study of books, documents, articles, statistics and reports of the Federal Government and State Governments. Personal contacts were made and information obtained from scientists, ophthalmologists, clinicians, pathologists, and others in the medical field interested in the problems of research in the blinding eye and other diseases. Some of the sources of information used and quoted from follow.

Furtherance of Medical Research by Dr. Alan Gregg, director for the medical sciences, Rockefeller Foundation.

Causes of Blindness Among Recipients of Aid to the Blind by Ralph Hurlin, Sadie Saffian, and Carl E. Rice, M. D., issued by the Federal Security Agency, 1947.

Fundamental Research in the Clinical Specialties by Dr. V. Everett Kinsey, Howe Laboratory of Ophthalmology, Harvard Medical School, Massachusetts Eye and Ear Infirmary, Boston.

Popular Misconceptions Pertaining to Ophthalmology by David G. Cogan, Howe Laboratory, Harvard Medical School, Massachusetts Eye and Ear Infirmary, New England Journal of Medicine.

Annual report of the Federal Security Agency, section 7, Office of Vocation Rehabilitation, for the fiscal year 1947.

Federal Security Agency, Public Health Service, National Institute of Health, Office of Vocational Rehabilitation, Social Security Administration, and Office of Education.

United States Manual, 1948.

Public Affairs pamphlet 124, What Do You Know About Blindness? (1947).

American Journal of Ophthalmology.

Archives of Ophthalmology.

American Academy of Ophthalmology.

British Journal of Ophthalmology.

Correspondence or personal contacts with the ophthalmological departments of John Hopkins University, University of Pennsylvania, Harvard Medical School, Institute for Vision of Ohio State University, Washington University School of Medicine, St. Louis.

Drs. Francis Heed Adler, Jonas S. Friedenwald, Edwin B. Dunphy, Fred A. Hitchcock, Phillips Thygeson (San Jose), Harvey E. Thorpe (Pittsburgh), Russell J. Nicholl, etc.

The Eye Bank for Sight Restoration, Inc.

Department of surgery (ophthalmology) of New York Hospital and Cornell University, College, of Medicine, John McLean, M. D., Dan M. Gordon, M. D.

Ophthalmological Foundation, Inc., Conrad Berens, M. D.

Perkins Institution and Massachusetts School for the Blind, Dr. Gabriel Farrell.

The New York Institute for the Education of the Blind, Merle E. Frampton M. D.

New York Association for the Blind.

American Foundation for the Blind, Inc., Robert B. Irwin, M. D.

National Society for the Prevention of Blindness, Franklin M. Foote, M. D.

New York Guild for the Jewish Blind.

Institute of Ophthalmology of the Presbyterian Hospital, New York, John H. Dunnington M. D.

1946 edition American Foundation for Social Welfare, Russell Sage Foundation.

1948 edition American Foundations and their fields, Raymond Rich Associates, 1948.

Directory of Activities for the Blind in the United States, etc., seventh edition by Helga Lende.

Etc.

Mr. PRIEST. Thank you very much, Mr. Ulmer. Are there any questions, gentlemen?

Mr. SADOWSKI. I might say, Mr. Ulmer, that it certainly has been a shocking and startling revelation to me to learn that only $400,000 all told has been spent in basic research and that only between $70,000 and $80,000 of Federal moneys have been contributed to the gross amount of $400,000. I am sure that there are not more than half a dozen Members of Congress who are aware of this situation. If they do become aware of it, I am sure they will feel like doing something about it.

Mr. ULMER. I too was shocked beyond expression when I learned of these facts. When I could not use my eyes I had a lot of time to think. I thought this problem out and I decided that I would in my own weak way try to bring some of these facts to the people. First I studied the subject, and in my files are reams of correspondence. I have had many interviews, and I have gone to different places to find the facts. In my own home State, at the Ohio State University, I asked one of the men in charge there how much they had spent last year on eye research and it was said that not $1 had been so spent because they did not have the money. That is a shocking situation and I am sure it comes because we have not been able to bring the facts before the public.

I am thankful that all of us have had the opportunity to lay before your committee these facts which are so true and so shocking in themselves that I am confident that the answer will be research for the blinding diseases and that it will finally be on its way.

Mr. Priest. Any other questions?

Mr. Dolliver?

Mr. Dolliver. I cannot refrain from mentioning a very good friend of mine who passed away during the war and who like yourself was a lawyer and suffered from blindness during his life but was not fortunate as you—Mr. Mike Healy, of my home town who was a Democrat and participated in a number of the National Democratic Conventions.

There are just one or two points of inquiry I would like to make, Mr. Ulmer.

You referred to the Institute of Vision at Ohio State University. Is that supported by State funds or by private funds?

Mr. Ulmer. They are trying to get State funds and I am trying to help them. They have also come to Washington and are trying to get some support from the Federal Government. They have a fine set-up, well staffed, but literally not a dollar with which to go anywhere. They will look to State and Federal Government and to private funds, but it is a slow, tortuous task.

I think Mr. Biemiller asked the question, I am not sure: What happens with the foundations? I think as a result of my study, I might give you some light on that.

The thinking of the foundation must be reoriented.

Mr. Dolliver. You are referring now to the medical foundations?

Mr. Ulmer. No; the charitable foundations.

Mr. Dolliver. I see.

Mr. Ulmer. I ran into one that has $43,000,000 in funds and in taking the matter up with them I found that not a dollar is devoted to medical research and the man who supplied the money for the foundation was blind.

I asked the question, "Why is it that your foundation does not support medical research?"

They said that in 1931 their board decided that they would apply the knowledge that they had and since that date the money of the foundation has been frozen. They have not spent any money for research.

I think that is a strange thing but I also think that if you arouse the interest of this country to the need of research in the blinding diseases and reorient the thinking of America to the use of money for fundamental research in blinding eye diseases, perhaps some of the foundations will change their present thinking. I think the situation came about perhaps from the common belief that blindness is hopeless. The answers can be found. I know from my own knowledge in the Howe Laboratory under Dr. Kinsey they are doing a marvelous job;

he is a modest man as was indicated by his statement to this committee. I am hopeful that under the direction of Dr. Kinsey Howe Laboratory will find the answer to blindness of prematurely born children the numbers of which are increasing.

When you go to a foundation, first they will dole out their money to you for 1 year or 2 years, or they will quit entirely after a short period, or will not give money for research. So that only by help from the Government, by bringing this situation to the American public are you going to reeducate private philanthropy which controls hundreds of millions of dollars. I have studied many of the books on foundations. It is startling to find how much money is tied up in charitable foundations and how little money comes from them for basic eye research. You must sit down with these foundations, talk with them, and try to change their thinking on short-time grants or lack of any money for fundamental research. The only way you can do that is with the help of Uncle Sam.

Mr. DOLLIVER. Is the Institute for Vision at Ohio State University an adjunct of their medical school there?

Mr. ULMER. I would say that it is an adjunct to the medical school.

Mr. DOLLIVER. Is it designed not only for research but for curative procedures as well?

Mr. ULMER. The institute is headed up by their own scientists, including ophthalmologists, optometrists and men from the medical school, and its engineering and other departments. In fact, Dr. Hitchcock, the head of that group is not a medical man at all. He is a scientist. He knows what fundamental research is and he has helped set up a research center and all they need at Ohio State University is dollars with which to go forward. At Howe they had been at it for 10 years, and are doing a splendid job of research.

Mr. DOLLIVER. You say that the general public in Ohio, that is, the public that is inclined to be charitable, and there are many of them of course in Ohio of that character, have responded?

Mr. ULMER. The Institute for vision has been organized within the past year.

Mr. DOLLIVER. Within the past year?

Mr. ULMER. Yes.

I will say for Ohio State University that they have at least made a good beginning. When you talk about Government statistics, and I hope I am not taking too much time, when you take the statistics the last book the Government put out is predicated on information that comes from 20 States only, and based on figures prepared in 1939 and 1940. The statistics in the country on the question of blindness are so meager that if as a lawyer I were preparing a case and I had to go back to ancient figures or data of that sort, I would say my case was ill-prepared.

The Government has hardly any current statistics of value on the blinding eye diseases.

Mr. DOLLIVER. This is another line of inquiry which perhaps you would not feel yourself qualified to answer but, nevertheless, you alluded to it and if you do not feel you can answer it, say so.

You referred to the work that is being done in Great Britain with respect to fundamental research in blindness and I a mreminded by your statement of an episode which took place a number of years ago.

An eye doctor with whom I was quite well acquainted in my home town was sent by the British Government to India to take care of a large incidence of the same eye disease from which you suffered. Can you give the committee any light on that program?

Mr. Ulmer. I have heard of it, but I am not familiar with it save to know that they have not as yet found the answer to the question, "What causes cataract?" Luckily the surgeons know they can remove the diseased lens of the eye and then furnish you with fine glasses and you see. If I take my glasses off I can see nothing, but when I put them on, I can see perfectly. What causes cataracts is unknown to medical science. In England they have just started their Institute of Ophthalmology, in 1948.

Mr. Dolliver. Mr. Chairman, a note has just been handed to me that Dr. Kinsey can answer my question in regard to the British program.

Mr. Priest. Fine.

Mr. Ulmer. Thank you. I am glad that he can answer it, because I am not a doctor and I am in deep water.

Mr. Priest. Very well, Doctor.

Dr. Kinsey. I am sorry but I thought it was an answer you desired in regard to the Institute for Vision at Columbus. The Institute for Vision at Columbus is an institute given to what I would call a paper organization at the moment. At Columbus they had four or five research divisions for various phases, zoology, a school of optometry and some work in the medical field under Dr. Keeler and they thought it would be nice to coordinate these efforts and set up, what they call it, the Institute for Vision.

Mr. Biemiller. Dr. Kinsey, in your statement I believe you mentioned the fact that one of the five institutions which you believe are now doing basic research is the University of Iowa?

Mr. Dolliver. Thank you for calling that to my attention.

Dr. Kinsey. They are well-known in this field.

Mr. Wilson. Mr. Chairman?

Mr. Priest. Yes.

Mr. Wilson. While Dr. Kinsey is on the stand I want to take the opportunity to point out that Mr. Ulmer on page 4 of his statement made reference to a very enlightening and important paper by Dr. Kinsey entitled "Fundamental Research in the Clinical Specialties." During the course of the proceedings I stepped down and asked Dr. Kinsey for a copy of it; I have it here. It is about five pages long and I ask unanimous consent to include it in the record.

Mr. Priest. Without objection, I think this may be included in the record and will be very helpful to the committee.

(The document referred to is as follows:)

FUNDAMENTAL RESEARCH IN THE CLINICAL SPECIALTIES

(V. Everett Kinsey, Howe Laboratory of Ophthalmology, Harvard Medical School, and Massachusetts Eye and Ear Infirmary, Boston)

The successful outcome of Government-supported research during the war has focused the attention of the public as well as professional groups on the desirability of continuing a part of this activity. Bills to provide funds for research in various branches of science are now before Congress. That these bills have not passed perhaps reflects the divergence of opinion of scientists on the details of administering potential funds rather than the temper of the people on the question of public support of research. It seems possible, therefore, that in the future Congress may appropriate funds for general research purposes. Although lack of funds is one of the chief factors limiting additional research, a comprehensive plan by which expansion may be carried out is just as essential as ample financial support.

In order to determine the present status of fundamental research in the clinical specialties and the readiness of clinical laboratories for expansion when more adequate financial support is provided, the writer has visited a number of medical schools. In general, the impression was obtained that research teams adequate to cope with the fundamental problems in clinical medicine are few. This was confirmed by many of the clinical men interviewed, who expressed dissatisfaction with the present lack of teamwork between clinician and scientist in basic research.

Among the points studied particularly in arriving at this conclusion were: (1) the organizational methods by which research is conducted; (2) the magnitude of the research, and (3) the extent to which the needs of the particular clinical specialty are fulfilled.

Only the larger university medical schools were visited, since it might be presumed that fundamental research would be conducted in these universities on as large a scale as anywhere in the United States. The schools were located along the Atlantic Seaboard, in the Middle West, and on the Pacific coast.

Typical of the conditions discovered is the situation in a clinical department of one of the midwestern universities. The head of this department is well known in his field. Clinical facilities appeared to be excellent, and space is available for making experimental studies. However, since the termination of a large grant 5 years ago no full-time investigators have been employed. Members of the clinical staff go to the laboratory occasionally and conduct occasional experiments as a part-time activity. No men from departments of basic science, such as bacteriology or biochemistry, have been assigned to work in the department. Plans have been made to obtain a research director who would be expected to devote half time to coordinating studies made in the department, a quarter to private practice (the income from which would comprise a significant fraction of the research budget), and the remaining quarter to work of his own choice.

Another instance which is not typical but which illustrates the consequences of half-way measures is the situation in a department located in a teaching hospital in a large medical school in the East. The department head is a clinician who previously gained an international reputation for his research work. Unlike that of most men in this position, his salary is adequate to allow him to devote full time to the department—in fact, the position was especially created so that he might have more opportuntiy for institutional activity, particularly for the "luxury" of research. When asked whether, under these apparently favorable circumstances, the research in his department was developing satisfactorily, his unhesitating answer was "no." Although he believed that the provision for full-time academic work was a step in the right direction, he estimated that 90 percent of his time was taken up with such administrative duties as obtaining new house officers, making rounds, settling petty squabbles, and numerous other details requiring the attention of a department head. Moreover, research by others on the staff is sporadic; an excellent young investigator was recently forced to enter private practice to make a living wage. The only full-time studies being conducted at present are carried out by a single investigator, a chemist.

In the two departments described definite efforts have been made by capable administrators to conduct research programs within the departments, but these have failed in their objective because of lack of funds. In departments in other institutions visited, no fundamental research has been attempted, and no facilities or personnel are available.

A method of conducting research which is being used increasingly is to assign members from departments of basic science to the clinical department or vice versa. Salaries and duties are divided. In a few instances this method has proved successful; more often the complaint is heard that the clinical man is unsympathetic with the choice of problem and that little actual contact exists between the basic scientist and the clinician, who spends most of his time in private practice. A variation of this arrangement is for the clinician to consult, either by periodic conference or when the occasion arises, with men in the preclinical departments. With the exception of one institution, where periodic conferences were implemented with laboratory work performed by full-time investigators, it was evident that this arrangement produced little more than conferences. The principal weaknesses of the conference method lie in the lack of mutual understanding and time, existence of other interests, and minor annoyances encountered in a joint investigation with busy coworkers frequently located on the other side of town.

Some research in clinical specialties is done in the basic science departments; these researches frequently lack continuity and are often of an analytical nature. As such, they are of great value. However, the mere accumulation of facts is not sufficient; it is important, in addition, to use them to establish new principles or to confirm old ones. This is an endeavor which requires background and insight both in the basic sciences and in the clinical field in which known facts are to be used.

In addition to research in medical schools and associated hospitals, an increasing number of studies, particularly in medicine, are being conducted in research institues and industrial laboratories. Despite obvious limitations, the majority of these are well organized and are performed by trained full-time workers. The clinical testing for both groups must be farmed out to nearby hospitals.

It is impossible to obtain an over-all picture of fundamental research in medicine without taking into account the increased emphasis placed on studying separately such diseases as cancer, tuberculosis, poliomyelitis, arthritis, and those affecting the heart. While these diseases are also the concern of different clinical specialties, they represent single entities, and the study of each is likely to become a specialty.

The number of people working in a given field is small indeed. This is illustrated by an example chosen from the specialty with which the writer is particularly acquainted, namely, ophthalmology. Glaucoma is caused by excessive intraocular pressure, which if untreated, results in blindness through excavation of the optic nerve head. This disease is the chief cause of irrevocable blindness in individuals past middle life and is typical of the dramatic type of illness whch mght be expected to stimulate research. How many investigators in the United States are devoting half or more of their time to studying glaucoma? Or, more important, how many are investigating basic physiological processes in the eye which might lead to a successful therapy? A generous estimate is three.

It is concluded from the information obtained that many halfway measures are being employed in an attempt to carry out research programs in the clinical specialties. As a result, the amount of fundamental research in the clinical field is extremely small in comparison with that in the preclinical sciences. Of the persons interviewed all but one is dissatisfied with the present state of investigational activities in his field, the exception being a man ready to retire. The implied excuse for this deficient stage is a lack of funds available over an extended period. Not only is basic research undeveloped in these fields of medicine, but it is apparent that if sufficient funds to carry out an intensive research program were immediately forthcoming, few departments have any trained personnel or well-laid plans for their effective use. This condition can be attributed in part to a defeatist attitude born of previous unsuccessful attempts to overcome the multiple difficulties inherent in combining an exensive research program with teaching and running a successful clinical department. It seems appropriate, therefore, to consider measures which might remedy this situation.

PROGRAM FOR EXPANDING RESEARCH

One way to expand research is to increase the number of laboratories investigating specific diseases. The inherent emotional appeal and the ease with which such programs can be delineated are strong tactical arguments in favor of this method. The disadvantages, particularly with small projects which may be forced to advertise their progress, are less apparent but just as real. There is danger, for example, that the interests of research workers may become narrow, that promising leads in the solution of other problems cannot be exploited, and that the feeling of constant pressure to turn up a "cure" may stimulate "long-shot" experiments at the expense of sound but more methodical investigations.

Another means of furthering research in clinical specialties is to establish research institutes in which investigations relating to a number of specialties could be performed. This method offers no appreciable advantage over the one to be recommended and entails considerable duplication of existing facilities and personnel.

A sounder plan, which does not call for significant changes in administration or physical layout, is to establish laboratories staffed with well-trained, full-time workers in the clinical departments of university medical schools. The objective is to develop the fundamental aspects of the clinical specialty and make these available to the postgraduate student. This method is not novel, since it has been successfully carried out over a period of years in the Howe Laboratory of Ophthalmology. Experience gained in this laboratory should be useful in considering a more widespread application of this method.

Historically, there has been little precedent for full-time investigators in clinical specialties; however, the tremendous developments in the basic sciences have suggested many new approaches to the solution of medical problems. These have complicated inordinately the methods of doing research. Whereas in the past many studies leading to fundamental discoveries have been made by isolated workers devoting their leisure time to research, present-day experience indicates that most progress comes from the cooperative effort of individuals having different training and background. Research of this kind is essentially a full-time job if facilities and personnel are to be utilized efficiently and if the quality of the work is to compare favorably with that in other branches of science.

THE LABORATORY FOR FUNDAMENTAL RESEARCH

The first step in establishing a research laboratory is to secure the services of an able director. At first thought it may appear that the head of the clinical department should also be the director of the research laboratory. This is inadvisable, however, because: (1) directing a laboratory is a full-time job; (2) the person in charge of a clinical department is usually interested chiefly in the practice of medicine rather than in basic research; (3) the head of a clinical department frequently lacks the scientific background which would qualify him to direct research; (4) the clinical professor may be inclined to encourage studies with immediate practical application rather than those of a more fundamental nature; and (5) the demands of his practice would preempt both the time and attention of the clinical professor. Actually, both positions are of such importance and involve functions so separate that a parallel rather than a vertical administrative organization is desirable.

The qualifications of the laboratory director should include a sound basic training in either medicine or science, a broad general interest and background in research, and, if possible, administrative experience. It is of greatest importance that the director be wholly in sympathy with the idea of a laboratory in which appropriate problems in basic science are investigated for the purpose of advancing a medical specialty.

A competent staff is no less important for the laboratory. Before selecting a staff it is necessary to recognize that its primary function is to conduct studies of a fundamental nature, not merely to be concerned with case-history reports, statistical studies, and the delineation of techniques.

In recent years advances in clinical medicine have paralleled great developments in the basic sciences. The growth of knowledge in both fields has been so extensive that to become a clinician, a physiologist, or a bacteriologist is a major achievement. Few individuals receive additional training or possess experience outside a single specialty. Accordingly, since the purpose of the research organization is to employ the concepts and techniques of the fundamental sciences in the investigation of problems in clinical medicine, it is essential that the staff include some individuals trained in preclinical sciences and others trained in a clinical specialty.

Each member of the staff should be prepared to conduct independent research and to work on equal terms in cooperative investigations whenever this is to mutual advantage. This type of organization assures that the scope of the work will be more broadly representative of the specialty, permits greater flexibility in the choice of problems, and takes advantage of the combined talents of the staff as a whole. That these talents consist of more than technical skill is not always appreciated. For example, the function of the preclinical scientist in research is frequently assumed to be merely that of a "glorified" technician. This was illustrated recently by the comment of a man who wanted to promote research in his clinical department. He said that what he "really wanted" was a biochemist who could perform analyses, the implication being that the success of a well-developed research program depends exclusively upon the performance of analytical work. In this kind of thinking, emphasis is on the results of analysis and not on the fundamental concepts which are prerequisite to intelligent interpretation. To this man, who is representative of many well-known clinicians of the older school, a person trained in the basic sciences is merely an adjunct to the laboratory whose scientific acumen is disregarded entirely and whose technical services are overrated. In this instance, the mistake is not in obtaining a biochemist but in misunderstanding completely his function in the laboratory. Therefore, to utilize the basic scientist fully it is essential that, in addition to using his technical skill, his intellectual capacities and talents be directed toward the conception and solution of research problems.

Following the same reasoning, the knowledge which clinically trained men possess concerning normal and disease processes should be applied to the solution of basic problems as well as to those of clinical significance.

The recommended individual approach to experimental problems may not appear possible in view of the limitations of specialized training already discussed. Actually, this may be true, but only during the initial stages of development. One of the chief attributes of an organization of this type is the day-to-day association of scientists and clinicians which eventually leads to mutual understanding of both fields. This, in turn, develops in each worker the ability to think in terms of both the clinical and scientific aspects of a problem. It is only when this point is reached that each member of the group is able individually to pursue effective independent research, and the laboratory as a whole is competent in all major phases of a specialty.

A secondary function of the staff is postgraduate teaching of basic science applied to a medical specialty. The laboratory staff should have the same teaching relation to the clinical specialty as the staff of the preclinical department has to medicine as a whole. For example, physiology might be limited to physiology of the eye or the urinogenital system, as the case may be. Experience in different branches of the specialty preeminently fits the laboratory staff for this task. It may also be desirable for the staff to assist in postgraduate teaching in clinical subjects, but all teaching should be so arranged that it does not occupy over approximately a quarter of the staff's time; in any case, it should not be permitted to bring research to a standstill.

The number on the staff will vary with the physical facilities of the department and with the financial support, but three is probably a minimum number for an effective unit, and four or five is better.

A laboratory staff in neurology, for example, might include two clinicians having different research interests, a physiologist, an anatomist, and a biophysicist. Arrangement should be made so that other members of the clinical department and investigators who might be assigned from cooperating preclinical departments could also participate. Temporary associates supported by term grants could assist the reseach group. Adequate technical assistants, secretarial aid, and an animal room attendant should also be provided.

If the laboratory unit is to function effectively, and if mistakes which in the past have resulted frequently in scanty and mediocre research are to be avoided, special consideration must be given to academic standing, remuneration, and tenure of the staff.

The system of rank in most clinical departments differs significantly from that in preclinical departments. It is customary in the former to have a professor, one or more assistant or associate professors, and a much larger number of assistants and instructors. In most instances the latter devote but a small fraction of their time to teaching and little or no time to research; they may continue without advancement in rank for life. Many of the men holding these lower ranks are outstanding physicians in the community, and their reputations are independent of their academic rank in the medical school.

In the preclinical departments, on the other hand, the staff ordinarily is much smaller and consists chiefly of men who devote full time to acedemic work. The same system of rank prevails, but the assistants, instructors, and usually assistant professors are young men. For them, rank determines their standing in the profession.

Since the staff of a fundamental research laboratory consists of career men, their academic status should be comparable with that of career men in other academic fields rather than with that of their coworkers in clinical medicine. In order to describe more accurately the type of work performed and to avoid the appearance of discrimination, it is preferable that the titles of the laboratory staff be different from those of the clinical staff, e. g. professor of neurological research, on the one hand, and professor of neurology, on the other.

The income of men in research does not approach that of the average practicing physician. If qualified physicians are to be attracted to medical research, a reasonable salary and satisfactory security in tenure is essential, particularly if they are to remain in this vocation. Salaries must compare favorably with those offered in basic science departments and in industrial research laboratories.

In such matters as academic standing, remuneration, and tenure the policy of the research laboratory may well be patterned after that of the preclinical rather than the clinical department. In problems of organization, on the other hand, this is not true because of distinct differences in personnel. For example, the staff of a biochemistry department ordinarily consists solely of biochemists, that of a bacteriology department only of bacteriologists, etc. In contrast, the complexity of fundamental research in the clinical field requires a staff of individuals from various fields. Strict adherence to the vertical system of departmental organization common in academic departments is unsuitable for the small staff of the laboratory. This is not to say that the usual academic advancement through the ranks should be abandoned, but to point out that as each staff member becomes, through experience and accomplishment, an authority in his own right, he should be rewarded with the rank and salary that he might have had if he had remained in his original specialty.

With rising costs, a budget for a laboratory involves some uncertainty. However, approximately $12,500 to $15,000 per year per staff member is probably a good estimate. This amount should cover salaries for the staff, technicians, secretaries, diener, and machinist, and the cost of animals, supplies, and equipment. A laboratory consisting of four staff members would require between $50,000 and $60,000 per year.

It is pertinent now to discuss several less tangible matters of importance in establishing research laboratories in the medical specialties. First, if the basic scientist devotes sufficient time and effort to becoming familiar with both the medical and scientific aspects of a specialty, it is possible that he may not be able to maintain in each the same proficiency as the more specialized individual. It has been said that he is neither fish nor fowl. This criticism might well have been made about the biologist or chemist who first transcended the horizons of his specialty to become a "biochemist," but few would deny that this "hybrid" has contributed more to the development of biochemistry than has the biologist and the chemist. The great contributions to the advancement of knowledge in the scientific aspects of medicine may well come from another "hybrid" who might be called the "medical scientist."

Secondly, in leaving an established field such as clinical medicine or basic science to work in a relatively new, composite field, the staff may experience a degree of professional isolation. If the laboratory is located in a hospital away from preclinical departments, this feeling of isolation is likely to be more acute in the basic science. It may be reduced by more positive recognition from the clinical staff of the department, by association of the basic science group with members of the preclinical departments, and by the formation of professional organizations created for workers in the special field. Membership in most medical groups is limited to those with a degree in medicine. Since the prime reason for this limitation concerns the practice of medicine, which is not involved, some special status in the local or regional organization covering the specialty should be created for the nonmedical members of the laboratory. This would be mutually advantageous, since it offers opportunities for professional contact and provides means by which clinical members may keep abreast of recent developments in the more fundamental aspects of their specialty.

As interest in fundamental research in the clinical specialties increases, societies for the exchange of papers, and possibly special journals, provide other ways of reducing the isolation. The trend in this direction is illustrated in ophthalmic research by the formation of the Association for Research in Ophthalmology, Inc., and by plans for a special technical section in an ophtholmological journal.

SCOPE OF THE PROGRAM

The number of laboratories necessary to bring fundamental research to a state of development comparable with that in other branches of science is dependent upon the number of clinical specialties involved, the proportion of total investigational activity in the fields for which these laboratories might assume responsibility, and the special requirements of any given specialty.

Although departments representing every clinical specialty were not visited, a definite need for increased basic research was expressed in the following fields: Dermatology, medicine, neurology, ophthalmology, orthopedics, otolaryngology, pediatrics, and urology. Since several others might be added to this list, a total of 10 specialties is a reasonable estimate.

It is beyond the scope of this paper to discuss the research needs of all of the specialties or to attempt a close estimate of the proportion of the total research in any one of these fields which ultimately might be performed in these laboratories. However, in ophthalmology four such groups might well be organized. If this specialty is reasonably typical of the average, the number of research laboratories in all of the fields would be of the order of 40. On this basis of the budget previously given, this would call for an annual expenditure of approximately $2,500,000.

IMMEDIATE OBJECTIVES

The financial requirements of the proposed program may appear to present insurmountable difficulties to any action which could be taken without Government support. Furthermore, because of the undeveloped and unorganized state of basic clinical research, it would be premature to attempt to put into operation so comprehensive a program or, indeed, any alternative plan comparable in scope without a preliminary test on a smaller scale. To this end, steps should be taken now to set up one research group in each of four specified clinical fields to serve as nuclei around which expansion could be planned. These four laboratories would cost approximately $250,000 per year and should be planned for a minimum period of 8 years, making a total expenditure of about $2,000,000. They need not be located in the same university, but the existence of a central authority to coordinate the whole effort and maintain unity of purpose is essential. In operating these test laboratories information would be obtained concerning the effectiveness of this method of conducting research which might well transcend in importance the scientific results. However, the latter alone should more than compensate for the effort made.

Provision should be made at specified intervals to evaluate progress in these laboratories. This evaluation and plans for enlarging the program might be made by the sponsor in cooperation with an independent board created for the purpose.

The immediate questions are: What means are available for establishing four initial laboratories, and who would be responsible for such action? It might appear that Government support is the logical answer. However, except in those fields of interest which fall within the domain of the War or Navy Departments or the Division of Public Health few governmental funds are yet available for for general distribution to medical laboratories. Since the research interest of the proposed program does not coincide with that of these Government agencies, private support must be obtained. This is not without its advantages, as the greater flexibility and altruism permitted by private foundations are especially valuable during the formative period of a new venture.

In general, funds may be sought from three main sources: Private individuals, public subscription, and foundations. They may be in the form of outright endowments or periodic contributions.

Appeals to private individuals and the public have proved successful in obtaining funds for studying cancer, poliomyelitis, and tuberculosis. There are two drawbacks to the use of this method for establishing the four test laboratories. First, an appeal to the public requires a highly organized campaign which depends on a previously existing organization; secondly, since most laymen and many nonlaymen do not understand the broad aims of fundamental research, the response is likely to be poorer than it has been when money was solicited for investigation of specific diseases.

There are numerous foundations whose purpose it is to further medical research. The history of medical education and research relates many instances in which the successful inauguration of a new venture depended upon receiving financial support from a foundation. The proposed program probably is no exception. However, its financial needs pose new questions to the foundations, for large sums are required over an extended period. In the past, most foundations have given only relatively small sums for specific projects and for periods rarely exceeding 5 years. The prospect of obtaining the requisite funds for establishing fundamental research laboratories in clinical medicine may depend upon the degree in which the foundations will allow precedent to influence their present policy. Whereas this policy may well have been a wise one in the past, an eminent authority, Dr. Alan Gregg, in the Furtherance of Medical Research (1941), has advocated that "the larger foundations return to making capital grants for endowment and for both the larger and the smaller foundations to make fewer grants for terms of 7 to 12 years instead of 1 to 3." Insofar as these viewpoints are accepted by the foundations and point to a trend in their policy, it is to be hoped that aid from them to expand fundamental research in clinical medicine will be forthcoming, at least until the public feels obliged to assume the responsibility for the support of research and thus makes it possible for the scientist to devote himself to science and not to raising funds.

The responsibility for initiating significant expansion of basic research in clinical medicine and for formulating a program worthy of support from the foundations or the public rests primarily with those forward-looking clinicians and basic scientists who realize that continued progress in medicine depends upon the discovery of new basic principles.

Mr. BIEMILLER. I would like to say to Mr. Ulmer that I am happy that he came here and presented his testimony. I have not only my boyhood attachment for Ohio but my mother suffered from cataracts and had a successful operation in Cleveland. I think it is a perfect example of what happens. My mother some 10 years ago began to stumble and miss a step here and there. Most of the neighbors said, "I guess you are getting old." I found out about it and went home. I found that that is what happened all too frequently. After a while her vision was restored to good sight.

I think that is an illustration of why we need sound research because I know my mother's experience is repeated hundreds and hundreds of times a day.

Mr. PRIEST. Are there any further questions?

Has Dr. Merle Frampton of New York arrived?

If there are no further questions, the committee will stand adjourned until 10 o'clock Tuesday morning.

(Thereupon, at 12:10 p. m., the committee recessed to reconvene at 10 a. m., June 21, 1949.)

ntll #256

NATIONAL HEALTH PLAN

TUESDAY, JUNE 21, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met, pursuant to adjournment, at 10 a. m., room 1334 New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills), national health, with respect to title II—medical research.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills), national health.

H. R. 3943, omnibus medical research bill.

Arthritis and rheumatism: H. R. 1908, by Mr. Javits; H. R. 1912, by Mr. Keefe; H. R. 1929, by Mr. Priest; and H. R. 1935, by Mr. Smathers (identical bills), to amend the Public Health Service Act to support research and training in diseases of arthritis and rheumatism, and to aid the States in the development of community programs for the control of these diseases, and for other purposes.

Mr. Priest. The committee will come to order.

The committee has before it this morning the sections or titles of the omnibus bills dealing with medical research, H. R. 4312, H. R. 4313, and also H. R. 4918, and a number of identical companion bills that have a title dealing with medical research.

We also have a number of bills dealing specifically with medical research in the cause, treatment, and diagnosis of arthritis and rheumatism. These are H. R. 1908, by Mr. Javits, of New York; H. R. 1912, by Mr. Keefe, of Wisconsin; H. R. 1929 by the chairman (Mr. Priest), and H. R. 1935 by Mr. Smathers, of Florida.

They are all identical bills.

In addition, we also are considering a number of research bills including H. R. 3943.

All of these bills are very closely related; many of them identical. Without objection, we will insert at this point a statement of our colleague, Hon. Jacob K. Javits, of New York.

(The statement is as follows:)

Statement of Representative Jacob K. Javits in Support of H. R. 1908

If agents of a foreign power were able, by agitation and sabotage in our great industries, to cause a loss of 97,200,000 workdays each year the Congress would lose little time to determine the course of action necessary to stop this depredation of our national strength. If we were plunged into a state of anarchy and 97 percent of our citizens beyond middle age were assaulted in the streets of the cities, in the fields, and in their homes, the Congress would not hesitate to dispel the chaos, restore order, and give protection to its citizenry so that they may go their way without hindrance. Yet this is not a hypothetical situation for rheumatism is responsible for the loss of 97,200,000 workdays each year in the United States and 97 percent of all persons who live beyond middle life develop some joint changes characteristic of rheumatism and arthritis. And older people are not the sole victims; rheumatic fever and rheumatic heart disease are the chief cause of death among children aged 5 through 19, rheumatic fever killing twice as many children as infantile paralysis.

The Congress now has the means at hand to help deal with this crippling blight on our human resources. The Arthritis and Rheumatism Act is designed to enlist the great resources of Government and private research, working as a team at long last, to give hope to millions of sufferers from these afflictions who have found no relief. Appended hereto is a summary of the provisions of this legislation.

Proposed Bill for National Arthritis and Rheumatism Research Act

SUMMARY OF PROVISIONS

The act provides for research, training, education, control, appropriations, and administration.

Research

There is provision for—

(*a*) The establishment of a National Arthritis and Rheumatism Institute.

(*b*) Grants in aid to public and private institutions and individuals for research projects as recommended by the National Advisory Arthritis and Rheumatism Council, including grants for the construction, acquisition, leasing, equipment, and maintenance of such hospital, clinic, laboratory, and related facilities and for the care of such patients therein.

(*c*) Research within the United States Public Health Service.

(*d*) Establishment of an information center.

(*e*) Refresher courses for physicians.

(*f*) Securing the assistance and advice of experts in this field here and abroad.

(*g*) Research in rehabilitation of victims of arthritis and rheumatism who have been left with residual deformities.

Education and training

Provision is made for research and clinical fellowships and traineeships in the institute and public and other nonprofit institutions.

Control

Provision is made for grants in aid to States to establish and maintain clinics and demonstrations.

Appropriations

Provision is made for allotment by the Surgeon General of such sums as may be necessary to implement the act to those States whose plans have been approved by the Surgeon General, on the basis of the population and financial need of the respective States.

Recipients of Federal grants for control of arthritis and rheumatism, including grants for demonstrations and the training of personnel, must spend for the same general purpose an amount from their own funds to be determined by the regulations.

Administration

The act is to be administered by the Surgeon General with the advice of an Advisory Council composed of the chief medical officers of the Department of Vocational Rehabilitation, Veterans' Administration, Army, Navy, and 12 appointed members—6 of whom are to be leading medical or scientific authorities in the field, and 6 of whom are to be leaders in designated fields outside the medical profession.

Mr. Priest. The committee is happy indeed this morning to have as the first witness on this important subject, Mr. Floyd B. Odlum. Mr. Odlum, we will be glad to hear you.

STATEMENT OF FLOYD B. ODLUM, THE ATLAS CORP., NEW YORK, N. Y.

Mr. Odlum. Mr. Chairman and gentlemen of the committee, with your permission I would like to read a statement that I have prepared for your committee.

Mr. Priest. That is quite all right.

Mr. Odlum. I am here today to urge favorable consideration of the bill before you to establish within the United States Public Health Service an Arthritis and Rheumatism Institute. I am here in the first place as chairman of the fairly recently formed Arthritis and Rheumatism Foundation; and in the second place as one who believes that real and economically justified relief by some fairly minor Government aid can be given at this time to a large segment of the more than 7,000,000 sufferers from arthritis. This is not only the humanitarian thing to do but also the economical thing to do for Congress to help through such modest funds to end the worst scourge of all, by which I mean the pain, crippling, and disability of rheumatism and arthritis.

My interest in the sick and handicapped does not come about primarily because I myself contracted one of the most crippling forms of arthritis while working with the Government in Washington during the war. My official connection with more than one medical institute at present and during the past will attest to this fact. However, I can speak with first-hand knowledge concerning arthritis and rheumatism as a result of an 8-year successful fight against it, and I have given a considerable period to the study of this particular affliction.

Our Arthritis and Rheumatism Foundation was organized a little more than a year ago to attack the problems of this disease on a national scale. We have had one fund-raising campaign. We are about to enter upon another this fall. All our efforts in these connections in support of research to find the cause and cure of arthritis, to educate the people concerning this disease, as well as our aid and treatment of patients, will continue even after the National Arthritis and Rheumatism Institute has been established by the proposed act, as we hope it will be. But our efforts, even though they are cumulative in effect, will be completely inadequate unless further support comes from public funds.

The Congress has very properly taken similar action with respect to cancer and heart disease by setting up institutes for such diseases within the United States Public Health Service and giving these institutes substantial financial support. It is quite right that this should be done with respect to cancer and heart disease. Both measures were well justified. They affect a great segment of our population.

But there is one disease which even more urgently demands congressional action to fight and that is arthritis and rheumatism. I say one disease because arthritis and rheumatism are more or less treated as one and the same disease which has many forms, and this disease or group afflicts more Americans than cancer, heart disesse, tuberculosis, and diabetes all combined. Arthritis and rheumatism strike 1 out of every 20 Americans. That is a higher casualty rate than this Nation suffered in the most savage war the world has ever known. It seems to me that the peacetime welfare of the population is no less important than the wartime security.

Many people look somewhat lightly on rheumatism and arthritis without suitable comprehension, because they are inclined to believe that these rheumatic diseases are not fatal. I call your attention, in this connection, to the fact that rheumatic fever, which is one branch of arthritis and rheumatism, is the chief cause of death in children between the ages of 5 and 19. Rheumatic fever alone kills twice as many children as does infantile paralysis. Even so, rheumatic fever cannot in all logic be regarded as the most important aspect of the problem of arthritis and rheumatism. The most important problem is the crippling of such a large segment of our population, which constitutes a real menace to our national health.

Of the 7,000,000 suffers from arthritis and rheumatism, more than 147,000 are completely disabled, more than 800,000 are partially disabled, and the balance are subject to chronic or recurrent pain.

This Nation would not sit by long if the 7,000,000 victims of arthritis and rheumatism were all residents of three or four cities. These cities would be properly characterized as major disaster areas and would receive the same fast sympathetic and effective help as any blighted area struck by earthquake, fire, flood, or similar disaster.

But in the case of arthritis, although we have these 7,000,000 sufferers, there are only about 200 free hospital beds in the entire United States specifically allocated for the study and treatment of rheumatism and arthritis, and only 1 person in 3 suffering from these diseases is treated by a physician. Of the 1 percent of rheumatics who get hospital care, few are permitted to remain long enough to receive much benefit.

Aside from the normal humanitarian desire to help so very many people who are suffering disability and pain, there is the economic aspect of the problem.

Arthritis and rheumatism cost the American people not less than $750,000,000 annually. Rheumatism and arthritis are not exclusively diseases of the aged; they cannot be written off as the inevitabilities of old age. They cut down men and women in their most productive years and strike all ages alike. Savings amassed in the best American tradition are wiped out by doctors' bills, with a never-ending pilgrimage from hospital to hospital looking for help that oftentimes does not exist.

In the annual loss to the economy of this Nation of $750,000,000 through arthritis and rheumatism, $250,000,000 is a conservative estimate of the cost in unearned wages, $128,000,000 is spent by taxpayers for relief allowances, and $100,000,000 is spent for medical care. There are in the neighborhood of 100,000,000 lost workdays through this one disease. The sum of $750,000,000 is more than five times the total appropriation for the United States Public Health Service in the period 1948. If only the relief allowance is taken into account of $130,000,000 whihc is a direct charge on public funds, immense savings would result from quick, better, and more research and more education of and help to patients.

Most everybody, including myself, is seeking for economy in Government expenditures and at this time above all others, but economy by no means is the same as refusal to invest productively. I know of no way that this country can get a better return in dollars, quite apart from the heavy return in health and happiness of its citizens, than by now appropriating up to $7,000,000 for grants in aid, study, and treatment of arthritis and rheumatism. This would be a self-liquidating project, profitable financially because it would permit the beneficiaries to contribute to the production of the Nation and to pay taxes rather than to be a burden on the Public Treasury. Apart from these savings, I hold to the thesis that the people as a whole, as represented by this Congress, cannot ignore such a large group of the population in chronic pain and state of partial disability. I am talking about approximately 5 percent of our entire population.

It is also a tragic fact that the workdays lost each year are lost to those least able to afford it. Arthritis and rheumatism affect for the most part persons in the lower income group. Hence, the relief allowances which must be borne by the taxpayers. Hence also, the strain on charitable and public hospitals and clinics to care for these patients.

Now let us examine the effectiveness of the treatment presently available to the victims of arthritis and rheumatism.

Except for something completely new which gives great promise and which I wish later to discuss, the advances in the finding of the causes and cure of arthritis and the treatment of the sufferers have been wofeully little, even though arthritis and rheumatism are almost the oldest diseases known to man. Today, of Federal research funds, only approximately 2 cents per disability from arthritis and rheumatism are being spent for research in arthritis and rheumatism as compared with $15.12 per disability in the case of cancer, 18 cents per disability in the case of heart disease, and 44 cents per disability in the case of venereal diseases. Large additional amounts from private sources are available for research in these other fields and in connection with infantile paralysis, but not in connection with arthritis and rheumatism.

I am not arguing that these expenditures should be cut down. I only wish to keep things in balance and point out the glaring omission. I wish to repeat for emphasis that, of the close to 7,000,000 sufferers from arthritis and rheumatism, close to 200,000 of them are completely disabled and another approximately 800,000 are partially disabled. The amount of money spent respectively on infantile paralysis and arthritis in this country is about an inverse ratio to the incidence of these diseases and the number of people crippled from them.

Our Government spends more on control of emergency outbreak of insect pests or on development of forest trails or on control of tuberculosis and Bang's disease in cows, and almost as much on control of white pine blister, as we are asking to be spent on control of arthritis and rheumatism in human beings who make up a very large portion of our own taxpaying and voting population. Perhaps the use of the word "taxpaying" is a little strong because a large part of the sufferers, instead of earning taxable income, must be supported by other taxpayers.

And now concerning the new discovery. There has been no time in the history of the world when a few million dollars could be spent on arthritis and rheumatism with greater results in terms of control of the disease and its pain and suffering than right now.

A remarkable discovery which has been reported during the last 2 months has made active research more necessary than ever before because, as never before, hope is given that the great scourge of rheumatism and arthritis can be removed promptly, provided a certain medical product or an effective substitute can be obtained cheaply and in quantity. I am referring to what is known as cortisone or, sometimes, as Compound E. Research is essential right now on a broad scale to determine that there is no better substitute for this product, that it has no bad after effects from continuous use, and how and why it works.

This compound E or cortisone has resulted from research work which has been carried on at the Mayo Clinic for several years. It is a hormone compound from the cortex of the adrenal gland of animals. It has been tested on approximately 30 patients, some of whom only receive it for 1 week on account of the shortage of the material. During its usage by these 30 patients they were, to all intents and purposes, as seen at least through a layman's eyes, about as before they contracted the disease of arthritis. That is to say the course of the disease had been reversed and much of the devastating work has been undone. But the doctors know that this compound and its results are merely the start in opening a new door to the finding of the cause and cure of arthritis and rheumatism. I have heard this point argued many times recently by the doctors and each time I am struck by the fact that an immense quantity of research work must be done immediately to bring this exceedingly important discovery to its fruition in the helping of hundreds of thousands of cripples. A way must be found to synthesize this hormone compound, for at present it would be so scarce and expensive that it would not be available to the mass of sufferers. Also, intensive research must quickly determine whether this compound is safe for continued use, for apparently like insulin in the case of diabetes it must be taken regularly by the sufferer from rheumatoid arthritis. But more than ever, research must now find out why it is that injection of the hormone in large doses, when there seems to be no basic true deficiency of such a hormone in the arthritis patient, causes a reversal of the disease. Doctors can explan this to you far better than I can, and some of them are here to do so, but much is to be learned and 7,000,000 people are waiting anxiously for the answer. They can expect, I believe, the necessary help from Congress under these conditions.

You can well imagine the feelings of these 30 patients when, after the compound was exhausted, they had to relapse from a state of health to their painful beds or wheel chairs. You can well imagine the feelings of the hundreds of thousands of sufferers from rheumatoid arthritis who have heard or are hearing about this treatment and possible cure but must continue to suffer while private researchers are laboring under the handicap of lack of funds to find the additional answers and to get the compound.

I get bundles of letters from sufferers who are crying out for relief when help seems just around the corner. Let us hope the corner is not a mirage.

These hundreds of thousands of sufferers have, I believe, a right to expect that immediate help will come from Congress, even more than in the case of many other strange diseases, for here it seems the answer is close at hand. At worst, it is an excellent gamble of a few million dollars against the return from public relief rolls to productive life of several hundred thousand people, and all this it would seem within a matter of a few days after treatment of the new hormone compound is made available to them.

I am one of the comparatively few who have weathered the storm of rheumatoid arthritis without any permanent crippling effects of a serious nature. My good fortune in this respect leads me to be actively soliciting for the many others who are daily going over the brink of bad health and painful suffering, not to return. I have given to the limit of my resources in time and means to help these sufferers. It is with knowledge of the facts that I ask Congress to step forward, and quickly, into the breach that has been opened. The suffering and crippling that comes from this disease is at present equal to that of a great war so far as our population is concerned. The cost of stopping this damage to humans is almost negligible.

Given a few million dollars to be expended aggressively and wisely under the guidance of the Public Health Service for research both into the disease and the way to synthesize the curative compound, or better yet to get a cheap substitute, I feel that I can almost guarantee a wiping out of the worst forms of arthritis and rheumatism within a matter of a year or two.

Yesterday, when I left my apartment to go to the office, my bags were packed later and brought to the airport, and the morning mail to my apartment was put in my bag. I found it last night and I read it during breakfast this morning. I had eight letters and all of those letters were asking for help; some of them for church, and so on, but four of them were from victims of arthritis and rheumatism. I am getting them every day until it sort of spoils my day, and I would like to just close my testimony by reading just one of these that came to me this morning. I brought it up with me, along with the others, if you care to see them. This letter is from a woman in Missouri. I will not give her name for obvious reasons, and I will leave out some of the nice things she had to say about me in the first paragraph.

Mr. PRIEST. I think perhaps you should include those. I think the committe would be very hapy to hear them.

Mr. ODLUM. Thank you. I will be very glad to read them if the committee desires:

> DEAR MR. ODLUM: I read about you and the wonderful things you have accomplished. And I wanted to write and ask if you would help me in any way. I saw the picture of you and your wife. You both look so happy and so much kindness written on your faces, I gues that is what give me the courage to write this—no matter how desperate our needs there are very few we can ask for anything.
>
> I am an invalid—18 years in chair and bed—arthritis has totally disabled me physically. I can use my pen and my only way of earning is selling magazine subscriptions by telephone. Now my arms are getting so that I cannot hold the receiver very long. Also I have chronic bronchitis which hinders me, too, from making my calls. A little girl helps me in and out of bed. I sit in my chair all day. I feel so helpless and discouraged that I can't earn more lately—you see there's no compensation in our State for the disabled. I hear there's a bill in Congress for our benefit—perhaps it will pass but in the meantime, I would be so grateful for any kind of help or if you could send an order for magazines—I have agency for all magazines.
>
> Trusting God that you will have a desire to help me and thanking you in advance,
>
> Sincerely,
>
> ——— ———.

Now, that is a pretty typical letter. There are probably 200,000 people in the United States that are either in that condition or worse, because some of them can not do anything. They just have to depend on others even to get their food or to turn in bed.

I have another one in this same pile of a man who has not looked at anything except the ceiling for years, and years, and years. I have others in this pile, another from a woman whose daughter is down with rheumatic fever. She asks for help. She does not know about this wonderful Compound E. If we could get a cure for that daughter's rheumatism, she would not have many of these disabilities which come afterward. We are doing all we can. I am doing all I can, and I think there is no sense of my giving all of my time and all of my fortune—I could not help but a few of them at best. It is much better for me to stay in harness and try in the way I can, as this morning, to get help for the whole group who are a very large segment and very needy segment of our whole population.

Thank you very much, Mr. Chairman.

Mr. PRIEST. Thank you very much, Mr. Odlum.

I think that the committee, if you care to do so, would be happy to have those other three letters included in the record.

Mr. ODLUM. I would be delighted to leave them with the committee. I just do not want to put the letters in the record and have their names used. If you will be kind enough not to have their names go into the record, I will be glad to leave them.

Mr. PRIEST. We will be glad to have them.

(The letters are as follows:)

DEAR MR. ODLUM: I read in June Life magazine of your successful business, of your lovely home and the honor of placement on the Research Board for Arthritis.

As I read of your success, I wondered if you could be of assistance to me. Kindly accept my letter in the spirit in which it is written.

I am a public school teacher. I have been ill for a year. Recently I took my disability pension. It is very small. I can return to my work any time within 5 years if my health permits. I am fighting desperately to regain my health. I had a good position and was very happy in it.

My pension does not allow me the medical help I need. I am constantly drawing from the amount I have carefully saved. I have spent $1,800 for medical help. I would like to go to the Mayo Clinic or any good medical center for further help. Also my living conditions need to be improved for improvement in health. I have one room with no facilities other than a sleeping room.

If you could help me financially, providing I recover my health so that I may be employed again, I would gladly repay the loan with interest. I am alone. My parents are gone.

Perhaps if you cannot be of any help financially you could advise me of some way in which I can obtain help.

Do you know of any medical center which has been successful in treating arthritis? For the past 2 months I have had some difficulty with neuritis.

I have appealed to the New York Teachers Association.

There is no provision for medical aid supplementing the disability pension although I am to return to the head of the association. I doubt they have the funds to help as many as they need to assist.

City welfare cannot be of assistance as you probably know unless all other resources are exhausted.

I would be glad to answer any further questions.

I refer you to John W. Parks, superintendent of schools, Academy Park, Washington Avenue, Albany, N. Y., Dr. Henry Hun, Washington Avenue, Albany, N. Y., Dr. William Richtmyer, 98 Willett Street, Albany, N. Y., Rev. Kenneth Wells, Church House, Chestnut Street, Albany, N. Y.

Very truly yours,

—— ——.

DEAR MR. AND MRS. ODLUM: I have been reading your story in the Life. You sure do look happy together. That is what it takes is love to make a happy home and always a smile.

My motto is: Life is like a looking glass, you smile in it and it will smile back.

My husband and I have always been so happy together. We have five children and have always tried to make a real home for them.

Now my husband is very ill in Indianapolis Hospital and doctor says he is incurable. I can't be with him very much as our daughter, Betty Lou, 15, is ill with rheumatic fever. This is the third time she has been stricken. It affected her heart this time. Other two times was her joints of her legs. The doctor says she should give up her schooling. She is 15 and would be in junior high school at English. My husband has been ill 12 years. He has had to doctor all this time, also Betty Lou.

When I was reading your story I thought I wonder if they would loan me $3,500 to pay myself out of debt. Only to you. I never go in debt only for have-to things, such as doctor bills, groceries, or sometimes clothing. We never buy tobacco, whiskey, or spend any money for foolishness as picture shows and like that. As we found out we can do without and go to Sunday school and church.

My children and I hitchhike 5 miles to English Sunday school and 5 miles back. Sometimes get a ride and sometimes we don't.

We don't have a car but as soon as I can get the $3,500 paid off, I want to buy a car for Betty Lou to drive as she will be 16 on November 1.

She could drive it to town and church and amusement places and keep her from worrying, and enjoy herself.

We are folks of appreciate type and what folks does for us, is always paid back in the same spirit.

My husband was in World War I. He drew $12 a month a while but was taken from him in 1933 and he never did get it back. We have worked so hard in keeping up our farm of 140 acres, and we make a good living considering our sickness and expenses.

In 1944 I worked at Charleston at Dupont. I would walk 5 miles to English and 5 back at night, ride bus 67 miles to work and from. I worked summer months of 1944 and '45. Sometimes I got a ride but I had debts to pay. I want to be honest and pay my way. I would get up at 2:30 a. m., prepare breakfast for family, leave at 3:30 in order to catch 5 o'clock bus, and some made fun. Some sat on streets and never worked. Some would pass me in cars which was some I knew and laughed. Listen! Wouldn't I rather been working helping win the war than to been in a fox hole or prison camps?

Some of them that passed me and laughed are enjoying their selves but sickness have never struck their home yet but their home is not as lovable as mine is for they never let God come in as a partner.

We have a mortgage on our home. Almost every day when the mailman comes there is a due bill. I have to cry for I don't even have the money to go see my husband as often as I want to. We have 200 laying hens—202 exact—4 brood sows with 34 pigs, 14 head of Jersey cows, which we milk and sell cream, and 4 Percheron mares, pretty as pictures. I don't want to sell off our stock. I keep trying to pay a few dollars each week and upkeep of farm.

That is why I would like to get money from only one person and stop these due bills.

I never go to town. In fact I don't have time. Caring of Betty Lou and managing the farm with the help of my two boys, 11 and 13. They are real workers—planning big to be farmers. Their dad is a real manager but he won't be here long to manage for them unless these treatments will help him.

If you would be interested in helping me, I could send you the best of references, banks and businessmen, also my pastor.

You may say, "Oh, she don't need it." Well, I do and I can't pay it all back next year but I will pay it a little at a time. I owe $3,496.36 to be exact now; that is mortgage, doctor bills, and all.

I know I would be the happiest person in the world, I know I could work rejoicing and think of not getting a due bill in the mail. I don't know how I would feel. I am so brokenhearted now.

I could give you a mortgage and when I save enough near $1,800 to get me a car, I will give you mortgage on it. I will pay you interest every year and some on principal. It may take 5 or 6 years. If you would help me, it will be confidential. No one will ever know how I got money to pay bills and it may be that one of my children might work at your plant some time. If you are lucky enough to get them. They are not loafers. They are nice children and taught to work.

Will you answer my letter and tell whether or not you can help me.

Yours truly,

——— ———.

DEAR MR. ODLUM: Am addressing this to you in your capacity as head of the newly formed foundation for arthritis research. Having been bedridden with arthritis for the past 16 years, the subject is of course very near to my heart and I have given much thought to the grave need for greater enlightenment on the subject. In analyzing the methods used in other research interests—cancer, polio, and tuberculosis—I have an idea that I believe would be a great boon to the efforts now being made.

The first thing that must be done is to educate the people to the seriousness of arthritis. Most extreme cases live almost a hermit's existence; therefore, only those in his immediate circle know his true condition. Consequently, the vast majority do not know how terrible arthritis can be, but everyone knows the seriousness of tuberculosis, polio, and cancer, since they are more dramatic. Most people, on meeting me for the first time, remark: "But you are so young. I thought arthritis was a disease of elderly people." This, as we both know, is far from the truth. Unfortunately this mistaken idea is very widespread and tends to cause people to be complacent about the disease—feeling that it attacks those who have passed their period of usefulness.

Hollywood, in recent years, has made pictures that, because of their realistic approach to various disabilities, have been most effective instruments in educating the people. The handless veteran in The Best Years of Our Lives did more to focus attention on the plight of the disabled veteran than can be estimated. The general public is better informed concerning mental difficulties since Olivia DeHaviland's vivid portrayal in The Snake Pit. Susan Peters gave one of the best performances of the year from her wheelchair and the general public has greater sympathy for the paralytic. Jane Wyman's academy award for her performance as the deaf mute is ample proof that, when dealt with realistically, physical affliction is not distasteful to the movie-goer.

Why couldn't a movie be built around the life of an arthritic? The leading character would not be the kind that is used in magazine illustrations, however—the current issue of Life, for example—who are "wrecked in mind and body." My choice for the role would be one who is perfectly well in mind and body, except for the loss of his powers of locomotion, and would have years of usefulness ahead of him if it were not for the ravages of this thing called arthritis. This limitation that is placed on a young, intelligent person is a much more dramatic example of its seriousness and would bring it home to the average person much more effectively than has been done heretofore.

The foundation which you head is to raise a sum for research, I understand. If you were to stage a Nation-wide drive for funds, I am sure that my town would stand high in per capita contributions and for this I feel that I could take a large measure of credit. The reason would be that I, even though I have not moved from my back, have led a pretty active social and business life, and have even taken part—from my ambulance cot—in numerous civic affairs, some of which were dramatic enough that the story of them is to be told in a documentary broadcast now in the process of being written and to be broadcast on CBS next fall. The people here understand that arthritis, even though it is a mystery to most of them still, is all that is keeping me, one of their number, from taking my place in the community and they would be quick to say that something should be done to prevent others from being so limited. Most pictures and stories of arthritics evoke in the viewer passive pity, but an accurate story of many arthritics would excite active sympathy.

There is ample drama in the lives of many arthritics to make a first-rate movie. Using my own case merely as an example, I do lots of things, but as long as I am held in the vise of ankylosis I shall find myself limited in every way. I write a daily newspaper column, have written a number of songs, some of which were good enough for publication by a big-name New York publisher—recently gave a 90-minute recital of my songs for the local music club. Have written a book, On the Level, which has to do with my on-the-level perspective during my 16 bedridden years. Yes, there has been romance in my life, too, but it has necessarily been limited.

You no doubt have connections in the movie city who might be receptive to such an idea if it were presented to you. I do not feel that such a picture should be a documentary. It could be made the kind of entertainment that would reach the masses and still carry the message that you and I are interested in getting across to everyone. The material could be gathered by interviews with arthritics throughout the country. It might even be possible to find an arthritic who would be suitable for the leading role in the manner of the handless veteran Russell.

My book manuscript might be of some help to you in presenting the idea and you are free to use it if you care to do so. I do not mean that it would do for the movie—it does not have enough story line for that—but it might be of some help in building a story.

If you find that my idea has merit, I should be happy to hear from you concerning it. In any case, however, I shall be wishing you and the foundation every success in your future efforts. I have undergone 12 hip operations during the past 2 years at Barnes Hospital and I know of something medical science is now doing for us.

With every good wish, I remain,
Yours sincerely,

——— ———.

Mr. Priest. Mr. Odlum, I appreciate very much your emphasis on the need for immediate scientific research in connection with compound E. I think we are too prone perhaps to accept a view that I have heard expressed so frequently, since the announcement of this discovery "there is no longer any research in arthritis necessary; they have found the cure; it is all over."

I think that the emphasis you placed on the great need for research and synthesizing the production and other phases of the use of it is extremely important.

There is one other question that I have. There are probably some other questions from other members of the committee.

I understood in your testimony that there were only 203 hospital beds in the Nation allocated exclusively for the treatment of arthritis and rheumatism.

Mr. Odlum. I did say that there were but 203.

Mr. Priest. That seems such a small figure to me, and I just had a feeling that perhaps I misunderstood you.

Mr. Odlum. No. Arthritis is a totally neglected disease, and it is one that is more widespread and causes more suffering than any other half a dozen diseases added together. They do not total as much. It is just accepted, except in the case of rheumatic fever, that it does not ordinarily kill. It is merely treated as rheumatism or misery or something else, and they get by with that, but in this case of compound E, we have started out as our foundation dream that we are going to lick this with a national foundation and a national program of research; that we were looking down what, for centuries, proved to be a blind alley.

Now, with this compound E, for the first time we can see the bright sunlight over the horizon, and we know where we are headed. It just energizes the whole research program. Now we need it more than ever.

Mr. Priest. Mr. Biemiller, do you have any questions?

Mr. Biemiller. Yes, Mr. Chairman.

May I say first I want to congratulate Mr. Odlum for stressing before this committee the need for conserving our human resources. While we are not neglecting the work that we have to do on our national resources, I have the feeling at times we are inclined to overlook the fact that if we do not start conserving our human resources we are headed for very serious trouble.

I think it is correct to point out the humanitarian approach, but also that there is a question of our national economy involved here in the tremendous number of manpower days that are lost because of these crippling diseases.

I have been most interested in the development of the arthritis and rheumatism foundation.

Are there any figures available as yet on the amount of funds you have been able to raise?

Mr. ODLUM. Yes; and in our first campaign, which was to a large extent organizational—for example, there were many areas where we did not attempt to raise money last year; did not attempt anything except organization and getting plans for this fall. We raised a total of approximately $600,000.

Now, it cost us something in the neighborhood of $200,000 to $250,000 to organize and get that money raised. We will not have to expend so much this year again, but we will have to still spend quite a lot of money.

We have an arrangement whereby we are organizing chapters of the Arthritis and Rheumatic Foundation in all of the areas of the United States. Generally, the plan is to use half of the net money that is raised for research on a national basis—that is, not just in New York, but so that it all dovetails in and there will not be a duplication of effort and it will all be jelled together.

This other half is going to be used for educational purposes and for treatment of patients.

Now, the first year we had too little to start any program of national research. We concluded that our best efforts would be to turn in as best we could on this compound E and work with the pharmaceutical houses to get them to work harder to synthesize this compound and get it quicker; and, secondly, to back the International Congress on Rheumatism and bring it to New York and publicize it on a national basis, as well as to bring to our doctors the world-wide knowledge that has been developed during the war.

We did that, and the Congress adjourned only a week ago. We had about 600 doctors there, specialists, from all over the world, specializing in arthritis and rheumatism. I think we contributed a very great deal to the aid of patients with these diseases by those hearings and, incidentally, we had the people from Mayo's there with their report and their slides and their moving pictures of their patients. I want to say that I went to Mayo's after they had treated 15 patients, and had enough of this compound E left for just a few patients for a week. They called in some of the other doctors who came out there and saw what they were doing and gave them, in advance of this congress on rheumatism, enough to treat, each one of these doctors, two patients for 1 week.

I was in Los Angeles at the time and went out to St. Vincent's Hospital to see the two patients who were being treated in that area. They had had their third shot of this compound. In other words, it was Saturday morning and they had had their first treatment Wednesday.

One woman had been in bed on her back with her arms and legs bent up on her chest and stomach for 5 months. She could not move in bed. She could not feed herself. She could not even touch her chin.

She was sitting up in her room when I went there. She was eating a meal. In fact, that was the sixth meal she had had in 24 hours. She had an enormous appetite and was feeling fine.

She got up from her luncheon table and walked up and down the hall of the hospital with me discussing this thing, without even leaning on my arm, and without the use of a cane.

The gentleman across the hall who had been crippled for years—as a matter of fact, could hardly get around—when we went to his room, got up out of his chair and danced a jig for me and he told me that that Friday night—that was Friday night, that the night before this, after 48 hours, he had called the hospital authorities and asked them if they would not let him out on the town for 2 or 3 hours, he felt so good. Now, the fact is, 7 days later—that is, 4 days after this—this was 3 days after they began treatment, they used up the rest of this compound. They had only had seven shots. They were both back in bed. The woman was back in bed, could not feed herself. She could not do anything.

Now, it takes about 7 months at present from the raw materials through about 30 chemical processes to get this little quantity of hormone products. I understand, and learned just yesterday, that they have been able to eliminate some of these chemical things that they have to go through and have shortened the time by a small percent.

But, at best, unless they find a way to synthesize this and make it up anew—it is a rare substance. They get it out of the slaughter houses from the bile of oxen and so on, and they have got to find a different way.

Anyway, the doctors can tell you that they will probably find the answer in other respects, because there are some diseases, I believe, that are caused by a deficiency of this same hormone that does not appear in arthritis. Therefore, it does not appear to be as a result of the deficiency of this hormone. There are some other things that happen in the human body, and I do not want to go on, because I cannot tell you intelligently what they are, but the doctors are here who can.

Mr. Biemiller. Will the doctors be here?

Mr. Odlum. Yes; the doctors are in the room.

Mr. Biemiller. Then I will ask them.

You anticipate that about 50 percent of the funds you raise will be used for conducting basic research and technical perfection of the discoveries which have already been made?

Mr. Odlum. Yes; and that is the agreement that we have with all of the local chapters.

Mr. Biemiller. You do not believe that the Government grant of funds for research or a research institute will slow up the voluntary efforts in that direction?

Mr. Odlum. Quite the contrary. If we get this kind of support and help from Congress, we think we can go out and raise two millions in the fall. I am sure we can raise that, and I am sure we can raise more than that if we have the support of this public-health contribution by Congress for the same purposes. We need it all and much more.

Mr. Biemiller. That is all.

Mr. Priest. Well, it has been true with practically all of these institutes which have been established, such as cancer, heart, and others, that the public contributions have increased proportionately as the Federal funds have been made available.

Mr. Odlum. That is very true.

Mr. Priest. That has been true, has it not?

Mr. Odlum. It has.

Mr. Priest. Mr. Bennett?

Mr. Bennett. I will yield to Mr. Gillette.

Mr. Gillette. Mr. Chairman, I want to say that I am slightly interested in this myself. I have a little touch of arthritis and know a little something about it. The doctor seems to have checked it.

Mr. Odlum. I spent 8 months flat on my back in bed with it.

Mr. Gillette. My trouble seems to be very much better. Whether it is just temporary or not, I do not know.

Mr. Odlum. Well, this disease, the doctors all tell us, is one of remissions and relapses, and I have become somewhat of an expert. As you held your hand up there, I had a pretty good idea of what your trouble was. The doctors in the room, I am sure, can tell you also that we are just on the verge of fixing up that type of thing.

Mr. Gillette. Well, I would like to have it fixed up.

Mr. Odlum. Yes, sir; just give us a few months and a little money and a little personnel to work on it, and these things will be cured.

Mr. Priest. Are there any further questions?

Mr. Bennett. Mr. Chairman.

Mr. Priest. Mr. Bennett.

Mr. Bennett. Mr. Odlum, one of the things that I think every Member of Congress is interested in is that while I believe there is no disagreement on the part of anyone who has given matters of this kind any thought, with respect to the necessity for finding the cure not only for arthritis but for others of the devastating diseases, for which complete cures have not been found as yet; but one of the concerns that I have, and I think other members have the same concern in considering legislation of this kind where we are going to be called upon to provide funds for research, is the amount of money that is necessary in a particular field that is involved on the one hand and whether or not sufficient funds are presently being provided by private institutions who are already carrying on research in these fields.

I wonder if you have any information on the extent of and the number of institutions, private institutions I am talking about—that are now engaged in carrying on research in arthritis.

Mr. Odlum. Oh, yes; we have a few. I believe that in the entire United States up until a year ago—and we have not changed it much as yet by our foundation—we hope to this coming year—that less than $200,000 was spent on research into the cause and cure of arthritis. For example, the Presbyterian Hospital in New York had some funds and have done quite a bit, and at Ann Arbor, Mich., the University of Michigan had a little money and have done some research on it; and Mayo Clinic has done some research; and I myself have provided some funds in the hospitals for special surgery in New York. Now there are a few more. I helped a clinic at Albuquerque, N. Mex. But, you can call them off on the fingers of your two hands, the places where this is being carried on.

Now, compare that with what I believe has been done in other fields. Congress has contributed, or is contributing this year, something like $30,000,000 for cancer, and the people are responding in a cumulative way to the call for cancer and it is going to prove out in results, too. Already they are on the verge of cutting down the mortality rate and the disability from cancer greatly.

Heart started in a small way and has climbed up until, I forget, but I think $12,000,000 or $15,000,000 is made available by Congress this year, and more than that is coming from private sources.

Now, there is nothing for arthritis. Nobody has given any thought to it. It is only now that the people are getting organized for the thing.

Mr. BENNETT. Mayo Clinic must have been spending some money on this.

Mr. ODLUM. The Mayo Clinic has been spending a little money, but very little; very little.

Mr. BENNETT. They worked on it for 19 years.

Mr. ODLUM. That depends on how you construe "worked."

Of course they have, because they have got people who are in the arthritis and rheumatism division who specialize on it and they have both been working on that in the hospital and the experts in the hospital have spent time on it, and they have been doing research and looking forward to it; but I went to Mayo's in 1941 when I broke down here in Washington. I was carried up there on a stretcher, in an airplane, and the same people who are doing this work on this cortisone or compound E are the people who took care of me there, but they did not have anything. They were working on rabbits and mice at that time, as many others are. But it was only a few, in a very few isolated places, and a few doctors, and interns who were working on it.

That is all going to be changed. We need to have doctors, specialists; we need to have doctors as researchers. They do not have a future in that field today.

Mr. BENNETT. Have you discussed the matter with the people at the Mayo Clinic?

Mr. ODLUM. Oh, yes. Of course, they are active in our foundation. The director there is on our medical committee, Dr. Boots, who is one of our great arthritis specialists here. He is working with Dr. Hench.

Mr. BENNETT. And do they support this legislation?

Mr. ODLUM. Very definitely; yes, sir.

Mr. BENNETT. The other day the Assistant Surgeon General testified here that they already have authority to carry on research in arthritis as well as multiple sclerosis.

Mr. ODLUM. I understand that that is the same position that they took in connection with the cancer bill and the heart bill. They have the authority to do it. My answer is to ask a question, Why the devil has it not been done? The fact is they do not have the funds and they do not do it. And, they have to have these special funds, and this special legislation, and directive in effect to get this done.

Mr. BENNETT. They may not have the funds, but evidently they have the authority in the law now.

Mr. ODLUM. They do have the authority, but they do not exercise it because they do not have the funds and do not have the personnel.

Mr. PRIEST. Will the gentleman yield?

Mr. BENNETT. Yes.

Mr. Priest. They do not have authority under existing law to set up institutes. They have authority to conduct research.

Mr. Odlum. We are asking for exactly the same thing to be done in the same health division as was done with respect to cancer and heart, for the very same reasons.

Mr. Priest. Are there any further questions?

Mr. Odlum, we greatly appreciate your appearance before the committee this morning.

Mr. Odlum. Thank you.

Mr. Priest. Our next witness will be Dr. Edward F. Hartung. Dr. Hartung, we will be glad to hear you.

STATEMENT OF DR. EDWARD F. HARTUNG, NEW YORK, N. Y.

Dr. Hartung. Mr. Chairman and gentlemen of the committee, Mr. Odlum has given you such an excellent survey of the size of the problem and of what should be done, that I will not repeat what he has already so excellently summarized.

I would just like to stress some of the points that he made and probably add to some of his points.

Mr. Biemiller. Mr. Chairman, may we have the doctor identify himself.

Dr. Hartung. My name is Edward F. Hartung, physician. I am an associate professor, clinical medicine, New York University, Bellevue Medical School; I am chief of the arthritic clinic at University Hospital of New York University, Bellevue Medical School.

There are four points that I would like to stress briefly in regard to Mr. Odlum's statement.

The first is the remark of the chairman, or one of the gentlemen, that possibly with the advent of cortisone most of our problems in arthritis will evaporate. I think it should be pointed out that rheumatoid arthritis is not the only problem in arthritis and rheumatism; that probably the most important problem, numerically, is the condition called osteoarthritis, and if there is anybody in this room who is over 40 he probably has osteoarthritis.

Osteoarthritis is an aging process which is of great importance numerically, and in other respects, and its production of disability and pain with advancing years. By advancing years, we do not mean decrepit old age, but around 40, when the condition of osteoarthritis usually has its onset. I would like to stress, too, the well-known fact that it is believed now that by 1980 over half of the population of the United States will be over 40, and that, as time goes on, the subject of osteoarthritis as a separate issue, aside from rheumatoid arthritis, will be of increasing importance.

Now, the cause of osteoarthritis is unknown. It is associated with advancing years, but whether it is caused by aging is still a question which requires research.

There are other problems in the rheumatic field, such as gout, which is important numerically and which may prove to be benefited by these new compounds.

The second point that I would like to stress is the importance of research versus patient care and to make us realize again the tremendous decrease in the need for patient care, with even the small advance in research in this field.

One example I would like to particularly bring out is one which has occurred in my own lifetime. I started in the field of arthritis and rheumatism about 1928, and at that time one of our most important concerns was gonorrheal arthritis. It was extremely common in New York City, where I practiced, and it occurred in young people, and it usually left very serious permanent disability.

At that time we had no important treatment for the care of these people, and the results were serious, permanent, crippling.

In the short 20 years that have elapsed since then, gonorrheal arthritis is a disease of inconsequential proportions. It was beautiful to see how research made this problam evaporate in the past 20 years, first by the advent of high-fever therapy, then by the introduction of the sulfamide compounds, and lately by the use of penicillin in gonorrheal arthritis.

I think laymen are too apt to underestimate the importance of research and how research can reflect itself in the tremendous decrease in the importance of patient care in many chronic conditions.

The other point I would like to stress is the question of rehabilitation of arthritic cripples, which I do not think Mr. Odlum mentioned. There are a great many people in the United States—how many, I cannot say, but the number is enormous—who are lying in bed, completely or partially crippled, unable to earn a living, unable to take care of their needs.

These people can be rehabilitated today by proper orthopedic and other means. We do not have to wait for new advances in research in rheumatoid arthritis or osteoarthritis to treat these people and rehabilitate them today. The means today that are here now can be used. The obstacle is the fact that these methods of rehabilitation require prolonged periods of hospitalization—3 to 6 months, to 12 months—and the financial problem is one which is beyond the scope of the average person and which is even beyond the scope of voluntary hospitals, and beyond the responsibility of municipal hospitals.

Our own hospital, for example, shuns rehabilitation problems because of the cost involved in housing these people for 3, 6, or 12 months.

In addition, these rehabilitation problems involve associated health in the form of physical therapy and other methods of rehabilitation, all of which are expensive.

But, I would like to stress the fact that, regardless of the state of our present knowledge of the cause and treatment of these rheumatic conditions, our methods of rehabilitation are here now and can be applied if the patient has the facilities to take advantage of them.

So that I am tremendously in favor of the arthritis and rheumatism bill.

I read some of those bills that have been presented. Which are the best, I leave to somebody with a legal mind.

All I would like to emphasize is that the stress on spending this money should be first and foremost on research; secondly on rehabilitation, and less, if at all, at the moment, on patient care. Thank you.

Mr. Priest. Doctor, we thank you very much.

The Chair desires to make his own position clear, since you refer to the fact that the chairman had commented on the possibility that intensive research might not be necessary because of this recent discovery.

I do not know whether you understood my position clearly or not. I was stressing appreciation for the fact that Mr. Odlum emphasized immediate and intensive research as the result of the discovery and stated that we hear sometimes from people who are not familiar with the situation that perhaps we do not need it; but the Chair feels very strongly that we do need that research, and I simply want to get the record clear on that point, thinking you might have misunderstood me.

Are there any questions?

Mr. BIEMILLER. Mr. Chairman.

Mr. PRIEST. Mr. Biemiller.

Mr. BIEMILLER. On the question of rehabilitation, Doctor, is there any work being done in the Veterans' Administration hospitals, in this field, at all?

Mr. HARTUNG. I am not familiar with the veterans' hospitals. I could not answer that.

Mr. BIEMILLER. I was impressed by your remarks that a proper course of rehabilitation would take fairly extensive hospitalization.

Dr. HARTUNG. Yes, sir.

Mr. BIEMILLER. I was simply wondering whether or not the VA work might be correlated with the over-all program which we are discussing here today; take some of these cases who are admissible to the veterans' hospitals and carry through.

Dr. HARTUNG. Yes. Of course, as far as rheumatoid arthritis is concerned, 3 to 1 are women. Of course, some of those might be admissible to veterans' hospitals. I am not familiar with the veterans' hospitals.

Mr. BIEMILLER. I think of one further point on the question of research. Mr. Bennett asked one or two questions of Mr. Odlum, which I would like to follow through on a bit more.

Is there any great amount of equipment needed in a hospital or institute to carry on research in this field?

Dr. HARTUNG. In the field of arthritis in general?

Mr. BIEMILLER. Yes.

Dr. HARTUNG. I would say that the equipment necessary is the ordinary equipment required for a research laboratory, such as instruments of precision, chemicals, and animals, and also an association with a hospital ward or hospital where these patients are being taken care of and can be observed.

Mr. BIEMILLER. There is no peculiar material or equipment that might be needed?

Dr. HARTUNG. I would say not; not to my knowledge.

Mr. BIEMILLER. Just the normal research set-up, such as one would expect to have in connection with a good medical school or a good hospital?

Dr. HARTUNG. I would say so.

Mr. BIEMILLER. Mr. Odlum mentioned four or five places where there is some work being done at the moment. I take it that in your own institution that some research is being done?

Dr. HARTUNG. Yes.

Mr. BIEMILLER. In this field?

Mr. HARTUNG. Yes.

Mr. BIEMILLER. Are there sufficient people equipped with a background of scientific knowledge, if funds were made available for research, so that it could be spread out, or would it be necessary to concentrate on existing institutions that are doing some research at the moment?

Dr. Hartung. Well, Dr. Currier McEwen, who is dean of the New York University Medical School, is going to make a statement later, and he would be able to answer those questions better than I.

Mr. Biemiller. I will reserve them for him.

Dr. Hartung. I would like to say this, however, that I think we, in general, and I, more particularly, favor having money allocated through this bill to existing institutions. We have many of them throughout the United States, particularly connected with medical schools, where we already have the set-up for this type of research. I would be more in favor, as a matter of economy, of having money spent in that way rather than having an institute in a physical sense being constructed specifically for that purpose.

Mr. Priest. Doctor, you have answered the other question that I had planned to ask on that particular point.

I gather from your statement that you feel that a grant-in-aid to the institutions prepared to do this research is far better than centrallizing it in one institution.

Dr. Hartung. I think it is far better and far more economical.

Mr. Priest. Mr. Gillette?

Mr. Gillette. I have no questions.

Mr. Priest. Mr. Dolliver.

Mr. Dolliver. Doctor, is there any relationship between the so-called rheumatic-fever field and the field we are now discussing?

Dr. Hartung. Decidedly.

Mr. Dolliver. There is?

Dr. Hartung. Yes. Rheumatic fever is part of our concern in connection with arthritis and rheumatism.

Mr. Dolliver. I see. Well, that is a disease that affects the heart; is it not?

Dr. Hartung. Among other things.

Mr. Dolliver. Medical science takes the position—does it not?—that it is directly related to arthritis and rheumatism.

Dr. Hartung. Well, you see, these partitions in medicine are man-made and not God-made. I mean the patient happens sometimes to fall into many categories as his disease develops and other complications arise. Acute rheumatic fever happens, among other things, to develop heart manifestations. So it falls, among other fields, into the heart field and the arthritic and rheumatic field.

Mr. Dolliver. Well, now, does this recently discovered medicine or method of treating arthritis have any impact on rheumatic fever?

Dr. Hartung. Apparently. I am not familiar with the compound, personally. I have never used it. But, from what I understand, it also affects acute rheumatic fever.

Mr. Dolliver. Thank you. That is all.

Mr. Priest. If there are no further questions, Doctor, we appreciate your statement.

Dr. Hartung. Thank you.

Mr. Priest. Our next witness will be Mr. Ralph B. Rogers. Mr. Rogers, will you give your full name and identification to the reporter for the record?

STATEMENT OF RALPH B. ROGERS, PRESIDENT, INDIAN MOTOCYCLE CO., SPRINGFIELD, MASS.

Mr. ROGERS. My name is Ralph B. Rogers. I am president of the Indian Motocycle Co., Springfield, Mass.

Gentlemen, I very much appreciate the opportunity to appear today to ask your support for the national arthritis and rheumatism bill.

I should like to take a few minutes of your time to tell you of my own personal experience with one of the diseases which falls within the scope of this bill. The disease I refer to is the worst killer and crippler of children in the United States today. You know it as rheumatic fever, or rheumatic heart disease.

You and I have read, or have heard, that there are more deaths which result from rheumatic fever than from all the children's illnesses combined. Let me repeat: There are more deaths which result from this form of rheumatism than from all the children's diseases put together. Perhaps even worse, this disease leaves most of its victims—and I am talking now of the victims who live—with a heart impairment which limits, and often destroys, the boy's or girl's usefulness in later life.

How many times do you pick up a newspaper and see where someone in his twenties, thirties, or forties, died from heart disease? How many times have we said, "Isn't it too bad such a promising young man or young woman had to die at such an early age?" What you did not know, and perhaps did not suspect, when you read that obituary, was that that death was due in most cases to an attack of rheumatic fever during childhood.

While rheumatic fever is known as a children's disease, it can and does strike adults. Now I want to tell you my story. In the winter of 1943, while I was working every day and every night to see that my companies met the requirements for Diesel engines, aircraft-landing gears, and hundreds of other vital components for our war machine, I contracted a streptococcal sore throat. A few weeks after this sore throat, I came down with rheumatic fever. For nine solid months I never set foot outside the hospital bed. For 4 months it was doubtful whether I would live. I was one of the lucky ones. I did live and I made a full recovery, although it took me 5 months to learn how to walk following the 9-month siege.

What happened to me in itself is not important, but what I found out during those 14 months is vitally important to you and to every American.

Picture yourself in my place. Here was a typical American who started with absolutely nothing, was lucky enough to live in this country so that I, despite lack of money, had been able to get a good education—even though it meant working in the daytime and going to school at night. Here was the typical American story of opportunity available to a boy who was willing to work his way up from nothing and now, at the peak of his usefulness, the best brains of the American medical profession told him: "Mr. Rogers, we don't know what rheumatic fever really is. We don't know what causes rheumatic fever, and we don't know how to cure it. There is absolutely nothing which we can do for you. You are financially able to buy for yourself the best nursing care and you may be fortunate enough to live."

Gentlemen, those words are awfully tough to take when you are suffering excrutiating pain. They are even tougher to take when you have battled for a living all your life and you have come to the conclusion that there is no obstacle which cannot be surmounted.

Yet, in those days of this painful experience, the facts were as the doctors stated. Here was the worst crippler and killer of American youth—and no way known to prevent it, alleviate it, or cure it.

I was fortunate in more ways than one. Not only did I survive, but I was financially in a position to get together every scrap of information on this rheumatic killer, and, as a layman, study that information.

I was astonished to find that in the group of diseases which fall under the heading of arthritis and rheumatism—and I now quote statistics from the United States Public Health Office, its related offices and the United States Department of Labor—that we here in the United States, even discounting the pain, agony, and misery suffered by the victims and by the parents and friends of these victims, that despite all this agony we actually lose the services and the talents and the skills of 7,000,000 Americans. Arthritis and rheumatism cost our factories, plants, offices, 97,200,000 lost workdays in the year 1947 alone. These figures are staggering. You know how much time and attention we give to the consideration of labor legislation because of the losses resulting from strikes, lock-outs, or other labor disputes. Yet here are 97,200,000 lost working days, or almost three-quarters of a billion lost working hours resulting from these diseases.

In terms of dollars and cents, the minimum cost estimate of these lost days of production is one-half a billion dollars. Add to this the $130,000,000 paid by taxpayers in the form of relief allowances for sufferers of this disease and more than $100,000,000 spent personally and institutionally for its medical care, and the minimum figures total nearly three-quarters of a billion dollars.

If you will excuse my levity, I do not think it inappropriate to comment at this point that the expenditure of $730,000,000 isn't peanuts—even today.

In typical American fashion, I promised myself that I would do something personally to put an end to such ridiculous answers as the medical profession was able in honesty to give to me. I determined that I should live to see the day when the medical profession could honestly say: "We know now what causes rheumatic fever and how to prevent it. We know now how to diagnose it early enough so that we may be able to prevent crippling hearts."

In 1944, with the help of a group of doctors headed by Dr. Arthur C. DeGraff of the New York University School of Medicine—then and now one of the leading authorities on rheumatic fever—we undertook research into these unknowns. With the help of the New York University School of Medicine, who used the money we donated for fellowships, and with the facilities of their research laboratories and information available at Bellevue Hospital in New York, we started research into the causes of rheumatic fever. A liaison was created with the Irvington House at Irvington, N. Y., which is a convalescent home taking care of 100 children each year who are stricken with rheumatic fever and whose families have no means to care for them. Our biological research is done at Irvington House. The doctors and the Medical care are all provided by our private resources and the cooperation of a few.

With the budget of approximately $50,000 per year, plus the donated time of some of the finest doctors in the United States, and the donated facilities of the New York University School of Medicine and the Irvington House—which facilities would probably cost us $3,000,000 to create—you may be interested in the accomplishments in the past 4 years. First, we know now what causes rheumatic fever and we know now how to prevent recurrences of rheumatic fever. We know now a great deal more than has been hitherto known, but there is much more which will have to be done before we can with certainty prevent the original onset—before we can with certainty diagnose this disease in its earliest stages—and before we can find a cure.

The point of recounting what we have been able to do privately is to show you that if we have been able to do this much, because we care, and because of the efforts of people who care, and with a small amount of money, that much more can be done if you gentlemen will see to it that the proposed arthritis and rheumatism bill is passed and that the $7,000,000 which is requested for work in this field—which $7,000,000, I remind you, is less than 1 percent of the economic losses sustained by us in the United States each year—is made available for the purposes envisioned in the arthritis and rheumatism bill.

I don't have to remind you gentlemen that these 7,000,000 Americans afflicted with arthritis and rheumatism can buy less, pay less taxes, and contribute less to the maintanance of himself, his family, and his country. The $7,000,000—looking at it coldly—is a good investment, as there can be no question that the increased earning powers of 7,000,000 sufferers would result in more than $1 per person which they could pay in Federal income taxes alone.

On the other hand, neither you nor I can look at this matter that coldly. After all, the diseases of arthritis and rheumatism are not something which can be regarded as the ailment of some nice old lady down the street. These diseases hit more Americans than cancer, heart disease, tuberculosis, and diabetes combined. They cripple our children and they cripple and kill our young men and our young women in their productive periods between the ages of 20 and 40—and let none of us discount the productive ability and the brain power of the arthritis victims even after the 40-year mark is reached.

You have heard today, gentlemen, that in this entire Nation today only 200 free hospital beds are available for sufferers of arthritis and rheumatism. Do you know that your own statistics prove that only 1 percent of rheumatism patients get hospital care and only 1 of 3 victims is ever treated by a doctor privately or institutionally? None of us here in the United States has the right to tell these sick people, "We are sorry, your illness is one of those unfortunate inevitabilities."

I asked for the privilege to come here today not only to tell you the story I have related and to give you my layman's opinion, but I asked for that privilege because it seemed unbelievable that you and I could read page after page of our tremendous national budget and then realize that the total national contribution of private, institutional and Federal agencies to combat arthritis and rheumatism is only $200,000 per year.

Contrast this sum with the other congressional allocations with which you are familiar. We spend $200,000 per year for our fight against arthritis and rheumatism while Congress allocated $29,866,000 for research and control of animal and plant disease in the year 1947.

I have no quarrel with the $29,866,000 if it is spent wisely for research and control of animal and plant disease in the United States, but certainly, gentlemen, 7,000,000 stricken Americans have a right to expect consideration from their Congress for more than $200,000 if that Congress can see its way clear to appropriate $29,866,000 for research and control of animal and plant disease. Those 7,000,000 Americans cannot appreciate, because of their suffering, all the interesting information concerning chlorophyll in plants and degenerative changes in animals. Those 7,000,000 Americans, in their agony and suffering, cannot understand why their problems and the problems of the million Americans who are subject and will be stricken today and tomorrow is less important than their Nation's interest in the research and control of animal and plant diseases.

As you know, it is the purpose of the national arthritis and rheumatism bill to establish a National Arthritis and Rheumatism Institute. Its primary objective is the establishment of grants-in-aid for medical research to qualified institutions.

This represents the first substantial effort to establish the facts to understand, prevent, and cure these crippling diseases. The medical profession regards this work as a must. I feel confident you and I, as laymen, will agree that it is a must.

Mr. Priest. Mr. Rogers, on behalf of the committee, I want to thank you for a most interesting, factual, persuasive, and, I think, convincing statement on this subject.

Are there any questions?

Mr. Dolliver. There is one part in your statement into which you did not go fully. You said that your investigations in New York had revealed the cause of this crippling disease, rheumatic fever. Are we capable of understanding and are you willing to tell us what that cause is?

Mr. Rogers. Let me put it this way: I can tell you now definitely something that we suspected or the doctors suspected.

Mr. Dolliver. It is nothing that you suspected, you mean?

Mr. Rogers. Well, it was suspected, and now it is confirmed, that the streptococci, which is one of the bugs, as we laymen would call it, we all have, sometimes gets to the point where you have a streptococci infection. Normally you have a sore throat. In every case of rheumatic fever that we have been able to study in our research, we have found that certain groups of streptococci—and the doctors can tell you the exact groups, if you want to ask them the question—that an attack by certain groups always precedes a rheumatic-fever onset.

Now, let me just be sure and make this point: That, although there might be a thousand people who had that same streptococci infection, all those thousand would not come down with rheumatic fever. A certain number of them would have rheumatic fever following that infection. But in no case would they have rheumatic fever unless it were preceded by the streptococci infection.

Now, while rheumatic fever is not a streptococci or the streptococci infection itself, it is linked with that streptococci infection. Consequently, the way we have been able to prevent recurrences of rheumatic fever has been to prevent the streptococci infection—which can be done, with both the sulfa drugs and penicillin—and thus we have been able to prevent the recurrences.

On the other hand, it would be entirely impracticable to expect the entire Nation to take drugs to prevent the streptococci infection. However, it has opened up a path.

And here is another path of research: We have been able to narrow down the number of hemolytic streptococci which are followed by rheumatic fever, and it is not impossible to conceive that some type of vaccine could be developed from those particular strains which could be administered, in the same way we have licked smallpox, that could lick this thing entirely and wipe it out.

Mr. DOLLIVER. That particular gap is the one that has not been bridged yet.

Mr. ROGERS. That is true; but that is the nice thing about medicine—that you don't have to know all of the answers if you can prevent the disease in the first place, or, for that matter, if you can cure it in the second place. There can be a lot of unknowns in between, and there always will be a great many unknowns.

What the victim or the potential victim is interested in is the prevention and the cure. And as a layman—it would be nice to know what this gap is and what happens, and maybe research will find it out—but as a layman, I would have been very happy to have had a cure, and I would be very happy for my four kids if I knew how to prevent it.

Mr. DOLLIVER. Let us pursue that cure idea a little further. The research that has so far been made through your generosity and the generosity of others, that research has not divulged any cure for this disease?

Mr. ROGERS. None whatever. The only hope that we have had is this recent one in this compound E, but that is too new and too untried.

Mr. DOLLIVER. And it is too expensive?

Mr. ROGERS. It is not a question of how expensive it is; it just can't be obtained.

Mr. DOLLIVER. You stated that you achieved complete recovery, and I suppose that was due not to any medicinal care you received?

Mr. ROGERS. Just plain luck.

Mr. DOLLIVER. And the fact that you had the physical vigor to overcome the disease.

Mr. ROGERS. I was just one in a thousand or maybe one in ten thousand who was lucky enough to get out of it without a heart impairment.

Mr. DOLLIVER. Thank you, Mr. Chairman.

Mr. PRIEST. Again we thank you, Mr. Rogers.

Our next witness will be Mr. Thomas E. Freeman.

The Chair appreciates, and I am sure the committee does, the very fine spirit of cooperation in moving along, and yet not overlooking any important testimony in the hearings this morning.

STATEMENT OF THOMAS E. FREEMAN, EXECUTIVE DIRECTOR OF THE ARTHRITIS AND RHEUMATISM FOUNDATION, NEW YORK, N. Y.

Mr. FREEMAN. Gentlemen of the Congress of the United States, it is a privilege to appear before you as a citizen who shares your interest in promoting the general welfare of our great Nation by improving the health standards of its citizens.

Mr. PRIEST. Would you give for the record your identification?

Mr. FREEMAN. I am executive director of the Arthritis and Rheumatism Foundation.

Mr. PRIEST. Thank you.

Mr. FREEMAN. I trust the information I shall present will prove conclusively that my purpose here is limited to that phase of the national welfare with realistic sympathy for the national economy.

Gentlemen, arthritis and rheumatism, considered medically as a single categoric disorder, are subject to cure.

To me its means that this great legislative body has the substantial responsibility of assisting in the deliverance of 7,000,000 Americans afflicted with arthritis and rheumatism. It is a disorder that has been treated as insidious, inevitable, and incurable from the days of antiquity.

Our hitherto hopeless national attitude toward the treatment and cure of arthritis and rheumatism is inconsistent with the American tradition of courageously meeting unhappy reality. By failing to bring our Nation's talent and wealth into an all-out attack on the problem, the people of the United States are perpetuating a wanton state of neglect.

Leading physicians of the United States are satisfied that arthritis and rheumatism, aflicting more people than heart disease, cancer, tuberculosis, and diabetes combined, are more hopeful of cure.

Rheumatoid arthritis present a phenomenon that is not now present in any of the other diseases. The phenomenon is known to physicians as "reversibility."

"Reversible" illness is one in which the patient experiences at least temporary recovery through a halt of the deterioration process and a seeming regeneration.

With the proper apologies for any of my own technical inaccuracies, I should like to ascribe the essence of this opinion to the celebrated Arizona rheumatologist, Dr. W. Paul Holbrook.

Although rheumatoid arthritis is but one of the many arthritic-rheumatic disorders, and while the history of this disease is not identical with the pathologies of others in arthritis and neuritis, to the physician and laboratory expert all the rheumatic diseases appear to have enough in common to justify any optimism for the treatment of all.

May I substantiate this optimism with two examples of "reversibility" in rheumatoid arthritis:

1. Nearly 80 percent of female rheumatoid arthritics recover at least temporarily from the disease during pregnancy.
2. A similarly large percentage nearly always recovers from rheumatoid arthritis when attacked by yellow jaundice.
3. In a lesser number of cases gold injections have produced "reversal" in rheumatoid arthritis.

To the physician, I am told, this "reversibility" suggests an important scientific premise for optimism: If the constitution of rheumatoid arthritis sufferers permits a seemingly accidental recovery, then medical science can profitably devote itself to learning the mechanics of change.

The rising lid on a steaming tea kettle was the undesigned phenomenon that made possible James Watt's deliberate design of the steam engine.

I am certain that you gentlemen can multiply this example a hundredfold in demonstrating that scientific achievement has been made by capitalizing phenomena of accidental discovery.

Lest there be any misunderstanding of item 3—relating to the use of gold injections for the treatment and cure of rheumatoid arthritis—I wish to make clear now that its use, I have been told, is limited because of the toxic results produced in some patients.

But, gentlemen, the work is still before the doctors just as the arthritis and rheumatism bill is before you now.

The use of $7,000,000 for grants-in-aid to recognized medical schools and hospitals can supply the physicians and laboratory technicians with the instruments for their work.

You have heard before and you will hear again the social side of the statistics originating with 7,000,000 Americans who are victimized by arthritis and rheumatism.

You will hear anew the staggering translations in terms of lost wages, lost production, lost taxes.

You will hear many more times about the suffering of the arthritis and rheumatism patients, and you will hear about the heartbreak that extends throughout their families.

You have heard before and you will hear again how men and women who labored hard and well found their savings exhausted in a vain search for relief.

I desist from amplifying these statistics only because they have been so well presented before.

I can only hope my own layman's translation of encouraging medical information has been half as impressive.

I should like to transpose the words in an epigram of American persistence, "Where there's hope, there's life." Certainly, gentlemen, life without hope is meaningless, and you can do much to provide this hope for millions of Americans.

Mr. Priest. We thank you very much for your statement. Are there any questions?

The Chair will state at this point that our next two witnesses are medical authorities, and if members of the committee have medical questions, they should direct them to the following witnesses.

We thank you again, Mr. Freeman, for your statement.

The next witness is Dr. Ralph H. Boots. Dr. Boots, will you come forward?

STATEMENT OF DR. RALPH H. BOOTS, ASSOCIATE PROFESSOR OF MEDICINE AT COLUMBIA UNIVERSITY, NEW YORK CITY, N. Y.

Dr. Boots. Mr. Chairman and members of the committee, I am an associate professor of medicine at Columbia University, and since 1928 I have been director of the Edward Daniels Faulkner Arthritis Clinic, which is the research organization at Columbia University for rheumatic diseases.

I might say that it is too bad that all of the physicians in the United States couldn't hear Mr. Odlum and Mr. Rogers and Mr. Freeman, because they really know as much about this problem or know more about it than the average doctor. I almost felt like getting on the train and going home after Mr. Odlum's speech, because he presented it so much better than any doctor I know that there wasn't much left to be said.

But it might be interesting to your committee to know something of the workings of an arthritis clinic in one of the larger hospitals. We have a budget of approximately $30,000 a year. We had hoped to have $60,000 this year, but I doubt if we will have it. At present it is $30,000, and a group of nine investigators or clinicians are working in the department. Three of these are full-time workers, and the remainder are part-time investigators who also practice medicine.

We see approximately 80 patients with some form of arthritis at each clinic session, most of these patients having rheumatoid arthritis.

In 1928, over 20 years ago, when we started our clinic, there were only two other investigative clinics with any appreciable funds in this country. One of these was at the University of Michigan, which had approximately $25,000 a year, and the other at Harvard University, which had a comparable amount.

The situation in regard to diagnosis and treatment was deplorable. Usually no attempt was made by the physician to make an accurate diagnosis and the patients were classified as "chronic multiple arthritis" or "monarticular arthritis," according to whether one joint was involved or a number of joints were involved. The favorite treatment was physical therapy or vaccine therapy. With this small amount of money used for research over this period of years, this attitude gradually changed and the physician was able to make an accurate diagnosis of the type of arthritis which the patient had. With the ability to make a differential diagnosis, treatments for each individual type were initiated so that in the past 20 years great advances have been made.

One year ago a small group of men interested in rheumatic diseases in this country asked the National Research Council to make an independent survey as to what facilities were available for research and how much money could intelligently be used for such purposes. The funds for this investigation by the National Research group were raised by the few doctors interested.

The National Research Council published a preliminary report in November 1948, suggesting a program which included (1) a basic approach for better understanding of the primary tissues affected in the various forms of arthritis; (2) careful clinical evaluation of all the physiological approaches; and finally, a consideration of the disease from the environmental and social aspects as it affects the people in our country as a whole.

In view of the shortage of the individuals well trained in this work, perhaps the most important item in the research program is the establishment of fellowships to give competent prospective investigators of promise the type of basic training and support needed for effective long-range research needed in this field.

In order to activate such a research program, the National Research Council estimated that the following amounts of money could be wisely utilized: In the first year $750,000; and in the second year $1,000,000.

However, this situation has changed. Since the publication of this report by the National Research Council, the announcement of the remarkable effects in rheumatic diseases with compound E and adrenocorticotropic hormone of the pituitary have been announced. The latter hormone is usually referred to as ACTH. Compound E is made at present by Merck & Co., and ACTH by Armour & Co. Armour & Co. alone spent between half and one million dollars in research work on ACTH this past year. They had no return on this money.

The introduction of these substances opens a vast new field of experiments, and it would be my opinion that the amount of money necessary for research work in the next 2 years should be many times that recommended by the National Research Council. I think the minimum amount, probably—the estimate was made that there were 7,000,000 sufferers from various forms of rheumatism—that the figure which Mr. Odlum gave of $1 per person, $7,000,000, that might be a good slogan, "A dollar for every arthritic."

If such research work is adequately financed, I think that you may definitely expect an advance in our knowledge.

Thank you.

Mr. Priest. Thank you so much.

I have just one question about the budget in your clinic. I understood you to say that you had a budget of $30,000 only for this year. You say that you have nine persons engaged in work in that clinic. Now, this $30,000, is that expended largely for payment of salaries to those persons engaged in that work?

Dr. Boots. I should say that most of it is paid for salaries. The university furnishes us with most of our equipment and animals out of their budget.

Mr. Priest. Are there any other questions?

Doctor, we appreciate your statement. It is your feeling, I gather, that some authorization for funds or the establishment of the institute for research in this field is rather vitally important?

Dr. Boots. I think that that is so.

Mr. Priest. The next witness is Dr. McEwen, of New York University College of Medicine.

STATEMENT OF DR. CURRIER McEWEN, DEAN OF THE NEW YORK UNIVERSITY COLLEGE OF MEDICINE, NEW YORK CITY, N. Y.

Dr. McEwen. Mr. Chairman and members of the committee, I am Dr. Currier McEwen. I am the dean at the New York University College of Medicine.

Like Dr. Boots and Dr. Hartung, there seems to be something mysterious about 1928 because they mentioned that, and it happens that that is the year that I started, or my interest or at least my active work in the rheumatic diseases, too.

Mr. Chairman, I have here a statement which I prepared, and as sixth on the list of witnesses it is natural that there is a lot of repetition here. If agreeable to you, I would prefer to merely hand this in for the record, and talk about perhaps some of the other things that haven't been covered.

Mr. Priest. That is quite agreeable and I think will be most helpful to the committee that way. Your full statement will be included in the record.

(The statement is as follows:)

Statement of Currier McEwen, M. D., Dean of the New York University College of Medicine

Mr. Chairman and members of the committee, the entire scientific world has applauded the support which the Congress of the United States has given medical research in recent years. Now, all of us who have carried on the attack against the rheumatic diseases have taken new heart at the bills which have been introduced to combat arthritis and rheumatism. I have read carefully H. R. 1929 and H. R. 3943 and am sure that either would give tremendous impetus to the study of these serious diseases and lead to the discovery of better means for their diagnosis and cure. It is my purpose to urge the great need of research in this comparatively neglected field rather than to endorse any particular bill. However, I do wish to say that I am one of the many who have been concerned at the apparent tendency toward the establishment of an increasing number of categorically established institutes. I believe that the necessary institutes can be most effectively established at the discretion of the Surgeon General and his Advisory Health Council, and therefore I believe H. R. 3943 is preferable to H. R. 1929. However, I must repeat that this is a decision which this committee is far better qualified to discuss than I, and I would urge only that the necessary steps be taken to provide the support for the research, fellowship, and training programs which are so urgently needed to conquer these greatest of the crippling diseases.

When one considers the tremendous toll of arthritis and rheumatism, not only in pain and disrupted lives but also in economic loss to the Nation, it is surprising that they have received so little attention in the past. Probably this is because public attention in the past has been drawn particularly to the killing diseases, and, with the notable exception of rheumatic fever, which is the principal cause of death in children of school age, the rheumatic diseases are not usually fatal. They do not kill but they deprive their victims of most of the things that make life worth living.

A comprehensive survey of chronic illness in this country reported by the United States Public Health Service in 1938 showed that there were then 6,850,000 victims of rheumatism and arthritis in the United States, and this figure has since then increased to well over 7,000,000 sufferers. This is by far the greatest group of chronic illnesses in this country, for its victims total more than those of heart diseases, cancer, tuberculosis, and diabetes combined.

The same survey of 1938 revealed that 97,200,000 man-days were lost that year to industry and other useful pursuits because of the rheumatic diseases. The medical care alone of these patients is estimated to cost more than $100,000,000 annually and to this must be added at least $130,000,000 in relief expenditures and $500,000,000 in lost production. These are shocking figures, to be sure, but who is to calculate the additional cost in pain and broken lives of 7,000,000 American women and children and men?

Great scientific strides have been taken in research on these diseases in recent years. Now, within the past few months, have come the reports by Hench and Kendall and their associates on the effects of 17-hydroxy-11-dehydrocorticosterone (cortisone or compound E of the adrenal cortex) on patients with rheumatoid arthritis and rheumatic fever. The importance of this discovery simply cannot be overestimated. The way lies before us to open up this new avenue of study and treatment with confidence that the means can now be found to control these diseases. To do so, however, will require the most painstaking and complex research. Whether this research will take many years or only a few will depend almost entirely on the financial support it is to receive. There has long been urgent need of such support of research on these serious diseases. Now, more than ever before, the opportunity to conquer them is at hand provided that support is given.

Dr. McEwen. I said that my work started in this field in 1928. I started to say that my interest in it started there, but that would not be true. I, like Mr. Odlum and Mr. Rogers and 7,000,000 others in this country, have more personal interest in these diseases. That is not in myself, but because of the fact that my father, who was a physician also, I think, was the most severely crippled patient with rheumatoid arthritis that I have ever known. Father was a surgeon who became so crippled he had to give that up, and then took up diseases of children, because a child he could hold on his lap and he could examine the patient that way, although he could not get up and go to a table.

So I grew up with a natural interest in medicine and with a particular interest within the field of medicine in this particular group of diseases. I have, therefore, carred on with that as my chief field of interest since I became a doctor.

I would like to say a word about some of the advances that have been made in relation to the program of research that we are all speaking so urgently for. A good start, and an awfully good start, has been made. When I first became a member or began attending the meetings of the American Rheumatism Association, some 17 or 18 years ago, really the meetings were the most extraordinary mixture of science and witchcraft that you would want to hear. Since that time the interest in rheumatic diseases has increased, and the scientific standing of the diseases, our knowledge of those diseases, has improved to a point where those—limited in numbers, to be sure—but, nevertheless, the quality of the scientific point of view of those working in the field, I think, measures up very favorably to those doing research in any of the other diseases.

There has been no better example of that than, of course, what has been said today on the work reported from the Mayo Clinic. In these last years a classification has come about. Dr. Boots spoke of the way in which, in 1928, these diseases were referred to by rather nondescriptive terms. There is no advance unless people mean the same thing when they are using a given term. So that classification and understanding of the differences between the various entities which fit into the total picture of the rheumatic diseases, arthritis, and rheumatism, that is one of the more important advances.

We have learned how, as Dr. Hartung said, to prevent and cure those very destructive forms of arthritis which used to be so numerous, which are caused by the nonmicrobial agents, the gonococcus and the streptococcus and the pneumococcus, and the others. They are practically unimportant problems today.

As Mr. Rogers has said, we now know how to prevent rheumatic fever. We cannot yet cure it, but at least we can prevent it.

Now, most important of all, in these last few months comes the report by Drs. Hench and Kendall on the compound E, which gives such hope not only in the treatment of rheumatoid arthritis but also rheumatic fever; and—I do not know how to say it—it just opens up the whole field. It gives new heart and new impetus to everyone who is doing research in this destructive group of diseases. Regarding the research that has to be done, Mr. Chairman, that question was brought up a little while ago; this is just the opening crack in the door, this report of Doctors Hench and Kendall and their colleagues. We do not know the mechanism; how does this work? We do not actually know that this is the active principle involved. It may be some secondary mechanism.

We know already, or at least it is probable, that ACTH, the hormone which Dr. Boots mentioned, works by stimulating the adrenal cortex to produce compound E. Now, it may be that compound E in itself is just somewhere along the way stations toward the actual principle that is new.

However, assuming that it is, if it is the active principle that is needed, then we have to know: Are there any untoward effects in giving this material to treat this disease, and are we creating something else that in itself is bad? That is going to take a most painstaking and careful study.

Then if it is safe, entirely safe to use, as it probably is, and if it is the basic principle we need, then how are we going to synthesize it, because as long as we are dependent upon the present methods of manufacture there never will be enough to treat more than just a tiny trickle of the total number of these patients who should have it.

Suppose compound E is not the active principle? Then we still have to go on and find out what that basic principle is. We need to know, then, is it something that is lacking, like insulin in the diabetic patient? Do these rheumatoid patients lack something that their adrenal cortex cannot make? Or is its adrenal cortex making it and then it is being inactivated in some way, or it is being neutralized so that it is not effective?

The question of its relation to rheumatic fever is important. Mr. Rogers mentioned the well-known and well-established fact that rheumatic fever is related in some way, some mysterious ways, to hemolytic streptococci infection. That is, I am perfectly certain, established.

We know, too, that compound E, or at least it seems very probable from the few patients that have been treated, that compound E also will control rheumatic fever as well as rheumatoil arthritis. If so, what is the relationship between this hormone activity and an infection with a hemolytic streptococci?

So there again, that is a very brief summary, or just a few of the possible fields that have to be explored.

To me, there not only is need today, Mr. Chairman, for research in this field, in the sense that it is needed in any group of diseases of unknown cause or unknown cure, but as one of the other witnesses has already said, here it is not something that we hope that perhaps through research we will obtain leads on; the lead, we have. The way is wide open, and I think what is accomplished from now on in this painstaking and complex research that is needed is going to be almost entirely related to the financial support that is provided. That research is going to take many, many years to bring about the control of these diseases, or a few years; it depends only on the availability of funds.

That is all that I have to say that occurs to me right now, Mr. Chairman, except perhaps to answer some questions, which I jotted down, that Dr. Hartung referred to me; or perhaps you would just prefer to restate any questions that you might have.

Mr. PRIEST. Are there questions? Do you have questions, Mr. Biemiller?

Mr. BIEMILLER. Let me make this observation. About 25 years ago I had the pleasure and privilege, as an undergraduate at Cornell University, of studying rather extensively in the field of the intellectual and scientific history of the Western World under two great historians, Carl Becker and Preserved Smith. As I remember the discussions we had in those days, there seemed to be a constant that always occurred in the field of scientific research. After a long and painful time you get to a certain point where finally two or three fundamental discoveries would be made and from that point on, in all fields of scientific work, it becomes a question of: Can you get the resources and the men to take off from those two or three fundamental discoveries and move ahead rapidly?

Do I gather correctly that you think you have reached that point in this field of research in arthritis and rheumatism?

Dr. McEwen. In this particular disease or group of diseases, rheumatoid arthritis and rheumatic fever and possibly gout and others, it looks as though we have passed that stage during which we have been looking for possible profitable leads; we have reached the point now where we have that. Now we are in the developmental stage where we are groping around and looking for possible leads. It is apt to come from the inspiration of a few. The men who are going to discover a new principle in medicine or medical treatment—they are geniuses and there are few of them.

But once they have turned up the lead, then we are at a point where we need many people and many hands to explore the different aspects of the problem. I happen to be on a committee which has been set up to project certain principles to guide the research with this compound E. Dr. Boots also is on that committee, and there are six others. The material is in such short supply that it would be too bad today, in the research which is done with it, to have useless duplication. A certain amount of duplication, of course, is necessary to check one another's results, but it would be far better at this stage if we can lay out in our various institutions those particular phases of investigation that we are best equipped to handle with our personnel and facilities, and another part of it to another institution. In that way, with a limited amount of material available and with a limited number of people trained to do this type of work, we will as rapidly as possible cover it or go the furthest.

Mr. Biemiller. If funds are available, do you think you have the trained people and the laboratory facilities available?

Dr. McEwen. No, sir, I do not think that we do. I think that we have the trained people to make a very good start, but that is one of the reasons why I am so interested to see, in the provisions of the various bills which I have read, the provision not only of funds for research but also fellowships and training grants to train those men who are going on to do the work in the future. Not only are funds very badly lacking for support of research in this extremely important group of diseases, but fellowships, by and large, have not gone to people who are interested in these particular diseases. So that we can make a good start, and by the time we have gone by that point and have reached that point in development where we need more and more hands to carry on the work, and more and more laboratories, by that time—that will be perhaps a year from now—by that time, through fellowships and grants that might be made, we would have the people equipped to carry on and expand the program.

Mr. Bennett. Is it your idea, Doctor, that a large part of the money which the Federal Government would provide for research purposes for this particular disease would be used for grants to private institutions that are able to accept the funds and use them advantageously?

Dr. McEwen. I believe that that is the most efficient way to do it, Mr. Bennett, and I believe that the Public Health Service shares that opinion.

Mr. Bennett. What part, in your opinion, should the Public Health Service or the Surgeon General play in the picture? The thing that puzzles me, because I am not an expert at all in these fields, is when you talk about the Federal Government spending money for research—and I am one that believes that they should provide funds for these various diseases for which cures have not been found—but I wonder how anyone is going to determine reasonably how this money should be spent and whether we should further enlarge or expand the Public Health Service to carry on a major part of this work, or whether the money that is finally appropriated or authorized should be used largely for grants to private institutions or universities, and schools, and other research institutions that are already in existence, to carry on part of the work. I wonder how you feel about that.

Dr. McEwen. Well, I think that I can speak pretty well for those concerned with medical education in general in this country, perhaps I should not say quite that, I have no mandate to speak for them, but the ones that I have talked with I think feel pretty much the same way about this. We have the greatest confidence in the way in which these funds are being handled at the present time. It is perfectly obvious that there should be certain central governmental laboratories, such as have been established at Bethesda in the National Institute of Health. I am sure that we have all agreed, in the medical and educational field, on that point.

We would, I believe, also agree, however, with the United States Public Health Service that the most efficient and economical way to accomplish the most in research is through the utilization of those facilities which already exist. There is a most complicated type of research of this sort, and one word on that.

In our particular school we have established what we call a study group on rheumatic diseases. The purpose of that is to cross departmental lines and to bring into focus on these rheumatic diseases, or their solution, the points of view and the skills of a dozen different departments.

Now, you cannot solve these problems today in splendid isolation. You can add or contribute little bits of clinical research, but I am sure that the most efficient way to attack these complex research problems is in the great university centers and other centers of that sort where you can bring to bear all of the diverse talents that you find in such institutions.

Mr. Bennett. You have endorsed Mr. Odlum's suggestion that Congress ought to provide a minimum of $7,000,000 the first year to start out with. Do you have any views on what proportion of that money, if that were the amount, ought to go, for example, by way of grants to private institutions, and what proportion ought to remain in the Public Health Service for their use in research by that agency?

Dr. McEwen. I think the pattern there is already set through the National Cancer Institute. That is as good an answer as I could give to that. There, a certain proportion of the funds are made available to the support of the work at Bethesda, and a certain proportion—and I do not know the actual percentage, just what those proportions are—but a certain proportion is made available in grants-in-aid for research; a certain amount is given to training grants and fellowships. And then—and this is a point that I would like to emphasize—I perhaps see this very clearly, sitting where I do as dean of a medical school—one cannot do research only with men. Men, by all means, are the most important, the brains to do it, but they have got to have the tools to work with. And I have been tremendously encouraged, myself, at the recent support in the construction of research facilities in various institutions throughout the country. It is an absolute essential, I am sure, if the best progress is to be made in research.

Mr. Bennett. Do you think the law authorizing this research ought to spell out how the funds are to be used, or do you think that it ought to be left up to the Surgeon General or the Public Health Service?

Dr. McEwen. I would prefer to see the latter, Mr. Bennett. I am one of those who have been a little bit concerned at the apparent tendency for an increasing number of categorically established separate institutes. I would much prefer, for example, the bill which is numbered H. R. 3943, to that numbered H. R. 1929, Mr. Chairman, for that reason. There, it leaves to the discretion of the Surgeon General and his Advisory Health Council, the setting up and the distribution of those funds.

Mr. Bennett. And if the Surgeon General at the time decided that the major portion ought to be spent directly through the Public Health Service rather than through private sources, you would be satisfied with that decision?

Dr. McEwen. I have enough confidence in the kind of men who are going to be Surgeons General, to feel that they would do the wise thing; and I am sure the wise thing is something that we would all be satisfied with.

Mr. Bennett. This is a big program, Doctor. I do not know how you feel about it, but I think that there is some danger in your program of research, and these other programs, in leaving or giving too much discretion or too wide a discretion to the people who are going to administer the program. I realize that they have got to have broad discretion, and I do not mean to infer that they should not; but I think somewhere along the line, if you are agreed on what the program ought to be, that at least there should be some limits on what the administrator can do in carrying out the intent of the law as everybody wants it to be.

Dr. McEwen. In the final analysis, the carrying out of it is dependent upon the appropriations that make it effective.

Mr. Bennett. That is true. But the way the appropriations are spent is very important, too.

Dr. McEwen. I would suspect if they were spent unwisely, they would not be appropriated again.

Mr. Bennett. That should be the case, but I am afraid very often it is not.

Mr. Biemiller. I would just like to carry that last thought of the Doctor's through a moment. It does seem to me that if appropriations are being spent very unwisely, that either the Congress is going to start cracking down or else the people are going to start cracking down on Congress, one or the other.

I take it, though, Doctor, that you have no great fear that under the program as outlined here, the Surgeon General might emerge as a medical dictator of the United States. You do have faith that the Surgeon General of the United States will always be a man of accomplishment in the scientific field and with a sense of responsibility to the people. On top of that, you will recall that in the bills there is provision—either in the bills for separate institutes, or in the omnibus research bill of Mr. Priest—for these advisory councils. And certainly it sems to me that even if the Surgeon General might be tempted once in a great while to go off on a tangent, the advisory councils in there would be competent enough to calm him down.

Dr. McEwen. I am sure that all of us, including the Surgeon General, would count on his advisory councils as one of his strongest assets and one of the best balance-wheels he and his department can have. I think that the advisory councils are of the greatest importance. I am sure of that.

Mr. Biemiller. Is it a fair statement to make that at least to date that the medical and scientific world is satisfied that competent people have been put on those councils and are giving proper advice?

Dr. McEwen. I have never heard any question of that. I have never heard that questioned.

Mr. Biemiller. I have just one further question on the details of setting up these institutes.

There is a third possibility over and above the omnibus bill of Mr. Priest and the specific bills in other fields that has been suggested, and as a matter of fact, the third possibility could also function inside the terms of Mr. Priest's omnibus bill. The suggestion has been made that we might set up a neurological institute to take in the various types of diseases that fall in that broad category and lump them under one head for administrative purposes. As you know, we have the cerebral palsy and epilepsy proposals, and so on. That, to some people, has semed a wise provision.

Dr. McEwen. I think that is feasible, Mr. Biemiller; but I believe, in my own opinion, a better way is a bill such as H. R. 3943, which makes all of those things possible at the discretion of the Surgeon General and his Advisory Health Council.

Mr. Biemiller. Thank you.

Mr. Priest. We have now, in the National Instiute of Health, six subordinate institutes—one on experimental biology and medicine; the microbiological institute; the Cancer Institute; the Heart Institute; the Dental Institute; and Mental Health Institute. Those are existing presently, and all follow the general line of the institute proposed in these separate bills, with the Surgeon General and an advisory council.

Just further adding to the question that Mr. Biemiller asked a moment ago, it has been my impression all along that the entire medical fraternity has been in the past completely satisfied with the allocations of funds through these institutes that now exist, under the plan agreed to by the Advisory Council with the Surgeon General.

I think also it would be true, would it not, Doctor, that an attempt to spell out too rigidly how these allocations should be made—and I agree in principle with what Mr. Bennett has said—but an attempt to do that with conditions changing as they do so frequently, might sometime result in allocations of funds that could not be advantageously used; is that not true?

Dr. McEwen. I agree with you on each of those points, Mr. Chairman.

I can say that at the time these things are accomplished, and these bills should be made effective, there might be a time when, I am quite sure, that it would prove desirable to establish an arthritis and rheumatism institute, and perhaps one in the neurological disorders.

On the other hand, if, after an intensive period of research on these, if they lead to the progress that we believe is just there, these accomplishments that we can reach out and almost touch today, within a few years or a certain number of years the amount of research necessary in those diseases might be encompassed in one of the other institutes and it would no longer be necessary to carry on a single one. That is why to me it seems so wise to have the institutes, or these individual institutes, established at the discretion of the Surgeon General and his Advisory Council. There is more flexibility.

Mr. BENNETT. I just want to make one further observation on that, Doctor. There is a school of thought in this country today that has the feeling that the larger the sums of money that the Federal Government provides for research the less incentive and the less money there will thereafter be provided by private sources; so that eventually, if that line of thinking turns out to be correct, eventually we will be in the position of having the major part of our research program financed by the Federal Government.

Now, if we do reach that situation, we might get ourselves in some trouble by leaving to the discretion of one administrator the parceling out of these funds to various organizations who might at that time be largely dependent upon Federal support.

While I agree that you probably cannot spell this thing out specifically, I merely want to point out that there is some basis for the feeling that you can get too much concentration of authority in your research program into the hands of the Federal Government, and thereby create some problems that you do not anticipate today.

Dr. McEWEN. I would have thought so, too, Mr. Bennett. It is one of the surprising phenomena of America, perhaps peculiar to this country, but the fact is that as the various institutes of health have been established and support has come for research from the Government, instead of hindering it has helped the private fund-raising efforts. I cannot explain it, but there it is.

Mr. BIEMILLER. May I just take up one more question, which I asked Dr. Hartung, and I believe he tossed into your lap: I raised the question whether the Veterans' Administration hospitals have been doing any rehabilitation work.

Dr. McEWEN. In rehabilitation, your question was. Indeed, they have, and very excellent work. I am chairman of the deans' committee, which works in cooperation with the Bronx Veterans' Hospital on Kingsbridge Road in New York. It is as fine a hospital as there exists in New York City. There is not one of our university hospitals that is better, or better staffed, or gives better care, than that one. Every one of us connected with it is proud to have that connection. The rehabilitation program there is an excellent one, indeed.

Now, I do not know all of the veterans' hospitals throughout the country, but I have visited three or four of them, and the ones I have visited have been fine.

Mr. BIEMILLER. On the basis of your own experience, then, the veterans' hospitals would offer a fruitful field for carrying into the rehabilitation field the scientific research that we hope will be accomplished, so that you have a ready-made place where work has been started which could be carried on and results checked?

Dr. McEwen. Yes; and I am happy to say that rehabilitation, that principle, is spreading to a number of the nonveterans' institutions, too. Dr. Howard Rusk has established—and we have a new department at our school with Dr. Rusk—and at Bellevue Hospital the city of New York has established, also under his direction, a very fine rehabilitation center. There is an increasing interest throughout the country in that, and I think that we will see before long more and more of an opportunity for the civilian to get the kind of care and rehabilitation that the veterans receive today.

Mr. Biemiller. What we need is really the push to get the program started.

Dr. McEwen. I think so.

Mr. Priest. If there are no further questions, Doctor, we thank you again for your statement to the committee.

There will be included in the record at this point letters from the Federal Security Agency, the Veterans' Administration, and the Treasury Department on the legislation before us.

(The letters are as follows:)

Federal Security Agency,
Washington, April 27, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Chairman: This letter is in response to your request of February 1, 1949, for a report on H. R. 1908, H. R. 1912, H. R. 1929, and H. R. 1935, identical bills to amend the Public Health Service Act to support research and training in diseases of arthritis and rheumatism, and to aid the States in the development of community programs for the control of these diseases, and for other purposes.

These bills, which, except for the substitution of arthritis and rheumatism, follow almost verbatim the provisions of the National Heart Act, would amend the Public Health Service Act in a number of respects. They would establish in the Public Health Service a National Arthritis and Rheumatism Institute and would specifically authorize the Surgeon General to conduct and promote research and training in arthritis and rheumatism through grants, fellowships, traineeships, etc., and to make grants for establishing and maintaining organized community programs of arthritis and rheumatism control.

COMMENT

1. The effect of these bills, with certain exceptions mentioned below, is merely to spell out with respect to arthritis and rheumatism the authority which Public Health Service already has with respect to health problems generally, including the problems of these specific diseases. Research on the subject of these diseases and related conditions fits into the research program of the Public Health Service at the present time. Many projects having application to these diseases are being supported by research grants from the National Institutes of Health. Intramural studies in this field are also being conducted at the National Institutes of Health.

The National Institutes of Health embraces six subordinate institutes:

Experimental Biology and Medicine Institute.
Microbiological Institute.
National Cancer Institute.
National Heart Institute.
National Dental Institute.
National Mental Health Institute.

While some the work of several of these institutes touches on problems relating to rheumatism and arthritis, the program of the Experimental Biology and Medicine Institute is particularly relevant. This institute has as its principal objective the improvement of methods of diagnosis, treatment, and prevention of diseases through study of fundamental physiological and biochemical processes. The component units of this institute conduct basic research in nutrition, physiology, pathology, pharmacology, biochemistry, physical biology, and chemotherapy.

The related activities of these specialized scientific skills provide a wide range of investigation appropriate for the pursuit of a research program for the increase of our knowledge of the heterogeneous group of diseases classified under the terms of "arthritis and rheumatism."

In addition to its present program in this field, the Public Health Service is planning for an expanded research program in this area upon the completion of its new clinical research center at Bethesda. In the allocation of laboratory space, equipment, and patient facilities at the new center, the Experimental Biology and Medicine Institute has been given allocations adequate to permit this expanded activity in the study of metabolic diseases. The wide range of adaptability and flexibility of these facilities for the synthesis of dietary, hormonal, vitamin, allergic, and constitutional factors in various diseases make the Experimental Biology and Medicine Institute a natural selection for the investigation and treatment of rheumatism and arthritis. The infectious factors in the causation of some types of rheumatism and arthritis can readily be studied in cooperation with the facilities and staff of the Microbiology Institute in the clinical center because of the unique close physical relationship of these two institutes in the center.

In view of the fact that research in rheumatism and arthritis already has an adequate organizational basis within the Public Health Service, the creation of an additional institute for this purpose would serve no effective purpose. On the contrary, it would undoubtedly result in an expensive overlapping and duplication of administrative structure, personnel facilities, etc.

2. It is true that in certain respects these bills would expand the present authority of the Public Health Service. For example, they would authorize construction grants for research facilities in the field of rheumatism and arthritis, as well as traineeships and training grants in this field. This additional authority would be comparable to that provided for cardiovascular disease by the National Heart Act. This Agency favors the extension of this authority beyond its present scope. We believe, however, that such authority should be extended to the entire field of health research and should not be limited or assigned to specific diseases only.

3. With respect to grants to States for control purposes, the Public Health Service already has general statutory authority in this field and we are not in favor of creating additional statutory categories for health grants to States. While it may be necessary to raise or remove present statutory limitations on the amount of general health grants to States, and to perfect in certain other respects the provisions pertaining to these grants, the creation of additional categories for specific disease-control programs would only add to the administrative complexity of the present grant-in-aid structure in this field.

Insofar as the bills refer to rheumatic fever, osteoarthritis, and so forth, in children, it should also be noted that programs of service are currently a part of the crippled children's programs organized by the States under the grant-in-aid provisions of title V, part II, of the Social Security Act administered by the Children's Bureau of the Social Security Administration in this Agency.

4. We note that the bills (sec. 2.) enumerate as one of their purposes that "rehabilitation of those who have been victims of these diseases, who have been left with residual deformities." If this refers to vocational rehabilitation, there appears to be no provision in the bills to carry out this purpose. The Office of Vocational Rehabilitation of this agency, however, administers under the Vocational Rehabilitation Act (Public Law 113, 78th Cong.), a program of grants in aid to State vocational rehabilitation agencies. Persons with arthritis and rheumatism are usually handicapped for employment and are therefore basically eligible for vocational rehabilitation services, which include appropriate medical treatment if such treatment is likely to remove or substantially reduce the condition as an employment handicap. It is frequently rather difficult to determine with our present knowledge of these diseases which cases will be eligible for medical services and which may be made employable or more advantageously employable through the provisions of other rehabilitation services. In general, we advise State agencies to accept only "burned out" cases of arthritis; i. e., those whose condition has become stabilized and is no longer active. Even with this group, methods of treatment are quite diverse and proceed largely on a trial-and-error basis. We hope, however, that the program of research now under way in the National Institutes of Health and outside with the aid of grants by the Public Health Service, may cast light on these problems.

The bills have a number of technical deficiencies. In view of our substantive comment, however, we refrain from burdening your committee at this time with questions of technical draftsmanship.

For the reasons discussed, while in full accord with the basic objectives of the bills, we cannot recommend their favorable consideration.

We are advised by the Bureau of the Budget that for the reasons presented in the above report the enactment of these bills would not be in accord with the President's program. In this connection the committee's attention is invited to the following statement of policy made in the President's 1950 budget message:

"For the fiscal year 1950, I am recommending appropriations sufficient to double the general health grants to States, raising them to $22,000,000, in order that the States in turn may extend and strengthen local health services. These stronger health services are an essential part of our national health program. I recommend that the present statutory limitation on the amount of such general health grants to States be removed from the Public Health Service Act, so as to authorize in later years the provision of larger amounts for the further improvement and expansion of local public health services. It is clearly more desirable to follow this course than to add new and separate grant programs or to continue to expand existing specialized health programs."

Sincerely yours,

J. Donald Kingsley,
Acting Administrator.

Veterans' Administration,
Washington 25, D. C., April 29, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Crosser: Further reference is made to your letters of February 1, 1949, requesting reports on identical bills H. R. 1908, H. R. 1912, H. R. 1929 and H. R. 1935, Eighty-first Congress, entitled "A bill to amend the Public Health Service Act to support research and training in diseases of arthritis and rheumatism, and to aid the States in the development of community programs for the control of these diseases, and for other purposes."

These bills propose to establish a National Arthritis and Rheumatism Institute in the Public Health Service and a National Advisory Arthritis and Rheumatism Council for the principal purpose of improving the health of the people of the United States through the conduct of research, investigation, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of arthritis and rheumatism and related diseases.

The proposed program would be admisitered by the Surgeon General of the Public Health Service under the supervision and direction of the Federal Security Administrator and the Surgeon General would be given broad powers in carrying out the purposes of the bills. The National Advisory Arthritis and Rheumatism Council would consist of the Surgeon General of the Public Health Service or his representative, the Chief Medical Officer of the Veterans' Administration or his representative, the Surgeon General of the Army or his representative, the Surgeon General of the Navy or his representative, and the Chief of the Department of Vocational Rehabilitation, who would be ex officio members, and 12 members appointed without regard to the civil-service laws by the Surgeon General of the Public Health Service with the approval of the Federal Security Administrator. The 12 appointed members would be leaders in the fields of fundamental sciences, medical sciences, education or public affairs, and 6 of the 12 would be selected from leading medical or scientific authorities who are outstanding in the study, diagnosis, or treatment of arthritis and rheumatism. The Council would act in an advisory capacity to the Surgeon General of the Public Health Service.

The Surgeon General of the Public Health Service would be authorized to make grants in aid to States, counties, health districts, and other political subdivisions of the State and to public and nonprofit agencies, institutions, and other organizations, in estalbishing and maintaining organized community programs of arthritis and rheumatism control. This proposal is similar to existing law (42 U. S. C. 246) with respect to grants to States, counties, health districts, and other political subdivisions of the States for the prevention, control, and treatment of venereal diseases, tuberculosis, and heart disease. The Surgeon General of the Public Health Service would also be authorized to accept gifts for use in carrying out the provisions of the bills pursuant to section 501 of the Public Health Service Act (42 U. S. C. 219).

These bills propose to establish within the Public Health Service another institute designed to cover one individual segment of research in the field of medicine. The committee may wish to consider the advisability of the development of multiple institutes for research into specific diseases on the ground that it tends to departmentalize research and investigation. Research in one problem very often leads to research in another and an institute confined to one narrow field of research might have a tendency to limit the vision of the workers.

In reference to the form of the bills it is noted that they contain several technical discrepancies respecting sectional numbering and lettering with apparently some inadverent admissions from the text of existing law.

Since the Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation except representation on the proposed National Advisory Arthritis and Rheumatism Council, no comment other than the above is offered. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that Office to the submission of this report to your committee.

Sincerely yours,

O. W. Clark
(For Carl R. Gray, Jr., Administrator).

Treasury Department,
Washington, March 11, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

My Dear Mr. Chairman: Further reference is made to your requests for the views of this Department on H. R. 1908, H. R. 1912, H. R. 1929, and H. R. 1935, identical bills to amend the Public Health Service Act to support research and training in diseases of arthritis and rheumatism, and to aid the States in the development of community programs for the control of these diseases, and for other purposes.

You are advised that these bills do not seem to be of primary importance to the Treasury Department and this department is not in a position to comment on their merits. However, the purpose of the last sentence of section 5 (a) on page 12 is not clear since it is assumed that payments contemplated by the act would be made by the Secretary of the Treasury in the usual manner, upon the basis of vouchers certified by the Surgeon General. Unless some definite object is intended to be accomplished by the language referred to, it is suggested that the language be deleted from the bill.

The Department has been advised by the Bureau of the Budget that there is no objection to the submission of this report to your committee.

Very truly yours,

E. H. Foley, Jr.,
Acting Secretary of the Treasury.

Mr. Priest. Without objection, we will insert four letters from the Federal Security Agency, and one from the Comptroller General of the United States.

(The letters are as follows:)

Federal Security Agency,
Washington, May 31, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

Dear Mr. Chairman: This letter is in response to your requests of January 7, 18, 19, 24, 27, and February 7, 1949, for reports on H. R. 62, H. R. 1206, H. R. 1261, H. R. 1315, H. R. 1375, H. R. 1436, H. R. 1573, H. R. 1645, H. R. 1727, and H. R. 2303, bills to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis. H. R. 1573 is specifically extended to related neurological diseases. This and other slight differences in these bills are not believed material for the purposes of this report.

This proposed legislation would provide for a Multiple Sclerosis Institute in the Public Health Service and would authorize the Surgeon General to conduct and promote—directly and through grants-in-aid, fellowships, traineeships, etc.—researches, investigations, public education, demonstrations, and control projects relating to the cause, prevention, and methods of diagnosis and treatment of multiple sclerosis and related neurological diseases.

Ample authority for the Surgeon General to conduct and make grants for research and investigations as to the cause, prevention, and cure of multiple sclerosis is already provided by the Public Health Service Act, and research on the subject of multiple sclerosis and related diseases fits into the research program of the Public Health Service. Research having an application to these diseases is now being conducted and will be increased with the expansion of existing facilities. Some recent fundamental research in the Experimental Biology and Medicine Institute of the Service has pointed to a possible relationship of these conditions to nutrition. Research in this field is also being carried on through the National Institute of Mental Health of the Service and the whole group of diseases affecting the spinal cord will be investigated by this new National Institute on a more extensive scale when the clinical research hospital at Bethesda is completed.

With respect to grants to States for control purposes, the Public Health Service already has general statutory authority in this field and we are not in favor of creating additional statutory categories for health grants to States. While it may be necessary to raise or remove present statutory limitations on the amount of general health grants to States, and to perfect in certain other respects the provisions pertaining to these grants, the creation of additional categories for specific disease control programs would only add to the administrative complexity of the present grant-in-aid structure in this field.

In view of these programs already under way or now being put into effect, we believe that the provisions of these bills calling specifically for research on multiple sclerosis and related diseases and for control programs in this field are unnecessary and that the establishment of a separate Institute for this purpose would be administratively undesirable.

We are advised by the Bureau of the Budget that for the reasons presented in the above report the enactment of these bills would not be in accord with the President's program.

Sincerely yours,

J. Donald Kingsley,
Acting Administrator.

Federal Security Agency,
Washington, June 9, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

Dear Mr. Chairman: This is in reply to your letter of May 18, 1949, requesting a report on H. R. 4738, a bill to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis, and for other purposes.

This bill is identical with H. R. 62 and certain other bills upon which we sent you a report dated May 31, 1949.

For the reasons therein indicated, we believe that the provisions of this bill calling specifically for research on multiple sclerosis and for control programs in this field are unnecessary and that the statutory establishment of a separate institute for this purpose would be administratively undesirable.

We are advised by the Bureau of the Budget that the enactment of this bill would not be in accord with the program of the President.

Sincerely yours,

J. Donald Kingsley,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, June 14, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in reply to your letter of June 3, 1949, requesting a report on H. R. 4973, a bill to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis, and for other purposes.

This bill is substantially identical with H. R. 62 and certain other bills upon which we sent you a report dated May 31, 1949.

Please consider our report on those bills as also covering the instant bill.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, June 14, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in reply to your letter of June 9, 1949, requesting a report on H. R. 5073, a bill to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis and related neurological diseases, and for other purposes.

This bill is substantially identical with H. R. 1573 and certain other bills upon which we sent you a report dated May 31, 1949.

Please consider our report on those bills as also covering the instant bill.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

GENERAL ACCOUNTING OFFICE,
Washington, February 9, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

MY DEAR MR. CHAIRMAN: Further reference is made to your letter of January 7, 1949, received in this Office on January 24 and acknowledged by telephone on January 27, requesting a report on H. R. 62, Eighty-first Congress, entitled "A bill to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis, and for other purposes."

A companion bill, S. 102, was introduced in the Senate on January 5, 1949. See, also, the similar bills H. R. 1206, H. R. 1261, H. R. 1315, H. R. 1375, H. R. 1436, H. R. 1573, H. R. 1645, and H. R. 1727.

Under date of July 9, 1948, this Office made a report on a similar bill, H. R. 7005, Eightieth Congress, to the chairman of the Committee on Interstate and Foreign Commerce, House of Representatives.

As stated in the aforesaid report, this Office has no information as to the need or desirability of the proposed legislation and, therefore, I make no recommendation as to the merits of the bill, H. R. 62.

It is noted that the language of section 704 (8) appears to be incomplete or incorrect—possibly the word "of" in line 24 on page 4 of the bill should be eliminated and a comma inserted in its place.

Pursuant to your request, two carbon copies of this report are enclosed herewith.

Sincerely yours,

LINDSAY WARREN,
Comptroller General of the United States.

Mr. PRIEST. The committee will stand adjourned until 10 o'clock tomorrow morning.

(Thereupon, at 12:30 p. m., the hearing was recessed until 10 a. m. Wednesday, June 22, 1949.)

NATIONAL HEALTH PLAN

WEDNESDAY, JUNE 22, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334 New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills), national health; with respect to title II, medical research.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills), national health.

H. R. 3943, omnibus medical research bill.

Multiple sclerosis: H. R. 62, by Mr. Fulton; H. R. 1206, by Mr. Chelf, H. R. 1261, by Mr. Van Zandt; H. R. 1315, by Mr. Buchanan; H. R. 1375, by Mr. Javits; H. R. 1436, by Mr. Tollefson; H. R. 1645, by Mr. Ford; H. R. 1727, by Mr. Joseph L. Pfeifer; H. R. 2303, by Mr. Mansfield; H. R. 4738, by Mr. Weichel; and H. R. 4973, by Mr. Mitchell—to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis, and for other purposes.

H. R. 1573, by Mr. Hoeven, and H. R. 5073, by Mr. Talle—to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis and related neurological diseases, and for other purposes.

Mr. Priest. The committee will come to order.

In continuation of hearings on medical research as contained in title II of the omnibus bills, H. R. 4312 and H. R. 4313, and various other research bills, identical or related, we are happy this morning to have a number of our colleagues in the House who have introduced bills on this subject and who have, in the past, as at the present, shown a vital interest in this type of legislation.

We will proceed with the hearings, hearing first the Honorable James G. Fulton, a Member of Congress from the State of Pennsylvania. Mr. Fulton, will you proceed.

STATEMENT OF HON. JAMES G. FULTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Fulton. May I just start with a short statement and then interrupt myself to let the other Members of Congress speak who have other hearings.

May I first refer to my bill, H. R. 62, as one of a series of bills which have been put in to deal with the disease of the central nervous system called multiple sclerosis.

Multiple sclerosis is a disease about which there is so little known that we cannot tell, either the number of people nor the distribution geographically of the cases, nor is there any known cure for it. But there is a tremendous number of new cases since the war period.

The outlook ahead is continued disability and death, in most cases.

In my own situation it has been brought graphically to the fore through the brother of a young man who worked for me, that took it.

He was a football player from Pittsburgh and first noticed it at about the age of 25 and died at the age of 33 from this crippling disease. His name was Baldini Mucci, of Bridgeville, Pa.

I had visited him quite a number of times as a friend and then as a Congressman, and one of the things that he had asked me to do was to see if he could not give his body for science. But there was no possibility of giving his body for science, because there was nobody or any institute which could work on the disease even though he wanted to help other people he was not given the chance.

So part of my appearance here this morning is on behalf of and speaking for a young man of Pittsburgh, Baldini Mucci, who died under circumstances which were such that he weighed only 54 pounds and had bed sores clear into the bones of his hips, and finally died of gangrene of bed sores and not from multiple sclerosis but the last 6 months of his life he spent completely paralyzed with his feet drawn up under him and his hands clawed and arms spastic, lying on his side, unable to control any of his body functions, but saying clear to the end that he never would give up. In the last few weeks of his life, the family, a mill family, hired a special plane to fly him to Philadelphia, at their own expense, to see if anything could be done for the young man, but they found that he was too far gone and nothing could be done.

So, the last time I saw him he said to me, "Will you keep on with this, even though I can't."

And that is one reason I introduced the bill.

The second reason is that I have had a secretary, a young man 31 years of age, who had been diagnosed as having multiple sclerosis. We have found since that it is another disease of the nervous system. The diagnosis has been so inaccurate on multiple sclerosis; we have had 20 doctors who said that it was multiple sclerosis, when it was not. Just last week, a physician at the Philadelphia Naval Hospital, a neurological surgeon, Dr. Wildebush, in conjunction with Dr. Knud Hansen, and Dr. Temple Fay, found the trouble.

So there is great need for this. The people that have seen anyone associated with them or their families go down day by day with no hope of cure—it is one of those things that you really have to live through to understand the need of help, and I can sympathize with every family that has it.

May I call first, Hon. Charles B. Hoeven, a Member of Congress, for a statement.

Mr. Priest. Thank you, Mr. Fulton. We appreciate your statement on this subject.

We will be very happy to hear Mr. Hoeven.

STATEMENT OF HON. CHARLES B. HOEVEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

Mr. Hoeven. Mr. Chairman and gentlemen of the committee, I appreciate the opportunity afforded me to appear before your subcommittee in behalf of H. R. 1573, which I introduced on January 17, 1949. This bill would amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis and related neurological diseases, and for other purposes.

I introduced H. R. 1573 in response to a heart-breaking appeal from a young mother in my congressional district who is afflicted with this dreadful disease. In the first of her many letters to me, she writes as follows:

> I am a victim of this disease which has taken my sight to a degree, has affected by right leg, and now is threatening other parts of my body. I have courage—courage which only God can give; but man—you men of Congress—can give me that living hope that I need so well. There is no cure, no money for research. Won't you please back this thing and make thousands upon thousands of helpless young people live again? I am young, married, and have two precious boys, 9 and 10. I cannot live the life of a normal wife and mother. My boys and husband cannot live their lives as they should. Please, please, I implore you, see that a bill for funds for research of multiple sclerosis is passed.

In addition to this letter, I have received several other communications from constituents who are afflicted with this disease or whose relatives are afflicted. When I introduced H. R. 1573, I submitted copy of my bill to Dr. Walter L. Bierring, commissioner of the State department of health of the State of Iowa. Dr. Bierring replied in part as follows:

> Multiple sclerosis is a distressing condition, and we know so little about its causes, prevention, or treatment. Any measure that will provide funds for intensive research and investigation of this problem is most worthy, and I am glad to know that you are sponsoring the same.

Dr. Bierring's letter only emphasizes the fact that for medical science multiple sclerosis, with its many unanswered questions, is one of the most baffling diseases in existence. Only the combined efforts of the community and science can some day hope to solve the mystery of multiple sclerosis.

I shall not go into detail as to the nature of multiple sclerosis. In short, it is a chronic nerve disease in which a patchy destruction of the nervous system occurs. It is also an outstanding social problem which has been sorely neglected. Most tragic of all, it is a disease of the young adult, stricken during the most productive period of life when he should be making his greatest contribution to society and has become the young parent of children who look to him for guidance and support. Very little is known about the cause of the disease and its corrective treatment. It strikes suddenly and fiercely, striking down thousands of young people in their prime of life.

The enactment of H. R. 1573 or another bill of like nature now being considered by your subcommittee would, in my judgment, be a step in the right direction. It would provide the research that is needed and would authorize the necessary expenditure of money to carry on the work. This is a humanitarian proposal. If enacted into law, there may still be hope for the thousands of victims of this dread ful disease. Let it not be said that the Congress of the United States has fallen short of its duty in trying to find the cause of a disease which is rapidly becoming a national problem.

Mr. PRIEST. Thank you very much, Mr. Hoeven.

The committee is aware of the fact that the Members of the House who are testifying this morning have other committees to which they must report as quickly as possible. Therefore, we are reserving questions in order to permit them to go to their other committees.

Mr. FULTON. I would like for you to call Mr. Tollefson.

STATEMENT OF HON. THOR C. TOLLEFSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WASHINGTON

Mr. TOLLEFSON. Mr. Chairman and members of the committee, I am one of those 12 or 14 Congressmen who have introduced what we have chosen to call multiple sclerosis bills.

My purpose in introducing it, of course, was to obtain the necessary Government assistance in the matter of research into one of the most devastating of diseases.

In my own town, the city of Tacoma, Wash., we have a clinic which is known there as the Multiple Sclerosis Clinic which has been and is treating about 120 people who are afflicted with this disease in that particular area. Among them is a very dear friend of mine who comes from a family of considerable means and would be able to afford the most expensive kind of treatment, but his ability to do so is of no avail to him, and he has consequently become interested in this clinic in Tacoma.

The clinic is conducted by a doctor there, Dr. Hinton Jonez, who is interested in the disease and who devotes his time, a considerable amount of it, without remuneration. He is nationally known for his work and has contributed papers on the subject of multiple sclerosis. The clinic is conducted in a hospital, St. Joseph's Hospital, which is a Catholic institution, that devotes its facilities without much if any remuneration, and victims of the disease are eligible for treatment in the clinic without too much regard as to the funds to pay for the treatment.

Financial assistance has been given to some extent by contributions from citizens in the community. The medical association in the community also has given considerable support. Nonetheless and despite the fact that this clinic is doing a marvelous job, all of the people who have been treated there, all of the individuals including the nurses in the hospital and the members of the medical association in Tacoma, recognize the fact that here is a disease which is beyond their ability to solve. As witnesses have testified it is a disease the cause of which is unknown, and the cure of which is unknown.

I would like permission, Mr. Chairman, if I may, to introduce into the record, file for the record, a small pamphlet describing multiple sclerosis and also a petition signed by patients having been or being treated in this clinic at Tacoma. This petition asks that I support this type of legislation.

I sincerely trust that this committee will give the legislation the most serious consideration and, of course, act favorably upon it.

Mr. PRIEST. We will be very happy to have the exhibits put into the record, and assure you, Mr. Tollefson, that the committee will give their careful consideration to it.

We thank you for your appearance.

Mr. TOLLEFSON. Thank you.

(The matter referred to above is as follows:)

JOIN AARMS

ASSOCIATION FOR ADVANCEMENT OF RESEARCH ON MULTIPLE SCLEROSIS, INC., AGAINST MULTIPLE SCLEROSIS

WHY EVERYONE SHOULD KNOW ABOUT MULTIPLE SCLEROSIS

The Association for Advancement of Research on Multiple Sclerosis was formed to do something about one of the most devastating diseases in the world, multiple sclerosis. For thousands of victims multiple sclerosis is a tragic reality. For medical science multiple sclerosis, with its many unanswered questions, is one of the most baffling diseases in existence. Yet, to the man in the street, the term multiple sclerosis is strange and unfamiliar. The time has come when the world should know about multiple sclerosis for this widely prevalent nerve disease has become an acute social problem. Only the combined efforts of the community and science can some day hope to solve the mystery of multiple sclerosis.

WHAT IS MULTIPLE SCLEROSIS?

The more that is known about multiple sclerosis, the more it is recognized as a common disease. Years ago, when its symptoms were not understood, it was considered rare and mysterious. Today, with refinements in diagnosis and a complete knowledge of its symptoms, multiple sclerosis is recognized as one of the most common nerve diseases.

Multiple sclerosis, also known as disseminated sclerosis, is a chronic nerve disease in which a patchy destruction of the nervous system occurs. Since multiple sclerosis is a disease of the central nervous system, its symptoms are present in almost every part of the body, resulting in widespread discomfort and suffering to the victim. The symptoms vary with the part of the nervous system involved, but the following are some of the more common ones found: Disturbance of vision, such as double vision; tremors of parts of the body (involuntary quivering); nystagmus (involuntary movement of the eyeball); weakness; difficulty in walking and balancing; numbness of parts of the body; speech difficulties; emotional disturbances; bladder trouble. In the course of the disease some patients suffer attacks which result in the appearance of new symptoms or greater severity of old symptoms. In the later stages of the illness some patients are incapacitated and confined to a wheel chair. The disease is also characterized by remissions or temporary relief from the attack in which an improvement in the condition of the patient takes place. The picture is not necessarily a dark one, however, as some patients are able to carry on their normal pursuits, having had relatively few attacks and remissions lasting many years.

Multiple sclerosis is an outstanding social problem which has been sorely neglected. It is a disease of the young adult, stricken during the most productive period of life when he should make his greatest contribution to society and has become the young parent of children who look to him for guidance and support. In many cases the victim becomes incapacitated without the means of earning a livelihood—in many instances within a year of onset.

ASSOCIATION FOR ADVANCEMENT OF RESEARCH ON MULTIPLE SCLEROSIS, INC.

Multiple sclerosis is one of the most baffling of the neurological diseases. Very little is known about its cause and corrective treatment. It strikes suddenly and firercely, causing the incapacitation of thousands of young people in their prime of life.

This association has been formed to bring aid to the thousands of multiple sclerosis victims all over the world who have always cried, "Why doesn't someone do something?"

The Association for Advancement of Research on Multiple Sclerosis, Inc., is dedicated to the goal of mobilizing all the resources at its command to—

Collect funds to stimulate and support research on multiple sclerosis and allied diseases.

Coordinate research efforts in this country and abroad.

Gather statistics on prevalence and geographical distribution.

Act as a clearinghouse for information on this disease.

Educate the public on the social problem of multiple sclerosis.

No one knows where and when multiple sclerosis will strike next. The public's only protection against the devastation of this disease is to act quickly and cooperatively against multiple sclerosis through basis research on this disease.

Honorary chairman:
  Dr. Tracy J. Putnam, director of Neurological Institute, Medical Center, New York City.
Medical advisory board:
  Dr. Leo Alexander, Boston State and Beth Israel Hospitals, Boston, Mass.
  Dr. Bernard J. Alpers, Philadelphia General and Pennsylvania Hospitals, Philadelphia, Pa.
  Dr. Edward M. Bernecker, Commissioner of Hospitals, New York City.
  Dr. Richard M. Brickner, Neurological Institute, Medical Center, and Mount Sinai Hospital, New York City.
  Dr. G. G. Deaver, medical director, Institute for the Crippled and Disabled, 400 First Avenue, New York City.
  Dr. Armando Ferraro, New York State Psychiatric Institute and Hospital New York City.
  Dr. James C. Fox, Jr., Hartford General Hospital, Hartford, Conn.
  Dr. O. R. Langworthy, Johns Hopkins Hospital, Baltimore, Md.
  Dr. Roger I. Lee, council of medical service, American Medical Association, Boston, Mass.
  Dr. Thomas M. Rivers, director, Hospital of the Rockefeller Institute for Medical Research, New York City.
  Dr. Colin K. Russel, Montreal Neurological Institute, McGill University, Montreal, Canada.
  Dr. Waltar F. Schaller, Lane and Stanford Hospitals, San Francisco, Calif.
  Dr. I. Mark Scheinker, University of Cincinnati, Cincinnati General Hospital, Cincinnati, Ohio.
  Dr. Francis F. Schwentker, Johns Hopkins Hospital, Baltimore, Mr.
  Dr. Ernest L. Stebbins, dean of School of Hygiene, Johns Hopkins University, Baltimore, Md.
  Dr. Gabriel Steiner, Wayne University, College of Medicine, Detroit, Mich.
  Dr. Israel Weinstein, Commissioner of Health, New York City.
  Dr. Harold G. Wolff, the New York Hospital, New York City.

ASSOCIATION FOR ADVANCEMENT OF RESEARCH ON MULTIPLE SCLEROSIS, INC.

Academy of Medicine Building, Fifth Avenue and One Hundred and Third Street,
New York 29, N. Y.

MULTIPLE SCLEROSIS CLINIC,
ST. JOSEPH'S HOSPITAL,
Tacoma, Wash., August 2, 1948.

Hon. THOR TOLLEFSON,
House of Representatives, Washington, D. C.

DEAR CONGRESSMAN TOLLEFSON: We have recently heard of Senate bill S. 2894 called the Multiple Sclerosis Act, as introduced by Senator Charles W. Tobey, of New Hampshire.

When this bill is introduced to the House of Representatives we sincerely hope that you will give it your undivided support. There is a great need for assistance in this fight against multiple sclerosis, commonly referred to as "creeping paralysis."

You should be proud of the work that is now being done in Tacoma. A special clinic is established at St. Joseph's Hospital under the direction of Dr. Hinton Jonez. At present there are over 120 victims receiving treatment in helping them to regain their normal way of living. The financial assistance of bill S. 2894 will allow this clinic to continue.

When you return to Tacoma be sure to visit the clinic and see the work under way.

Sincerely.

Fred Shockley, 1545 East One Hundred Forty-seventh Street, Seattle, Wash.; Bryon Seely, 1323 Washington Avenue, Chehalis, Wash., Geo. A. Kaypack, 2331 South M, Tacoma, Wash.; F. E. Clasen, Route 5, Yakima, Wash.; Mrs. J. C. Lewis, 1324 Felts Road, Spokane, Wash.; Laura Appeerbach, 5426 Forty-first Southwest, Seattle, Wash.; Hervey M. Petrich, 3424 North Nineteenth, Tacoma, Wash.; F. A. Zanoni, Route 3, Box 1950, Auburn, Wash.; Dorothy Harris, Route 4, Box 173, Puyallup, Wash.; L. H. Bristol, 11702 South G, Route 10, Tacoma, Wash.; John Gilmore, Butte Mont, 1711 South J, Tacoma, Wash.; Marjorie Rockwell, 782 Pennsylvania Avenue, Chehalis, Wash.; E. Labse, Seattle, Wash.; L. Christiansen, 2645 Forty-ninth Avenue Southwest, Seattle, Wash.; Mr. Joe N. Ely, Box 141, Kennewick, Wash.; Mrs. Lulu Ely (victim), Box 141, Kennewick, Wash.; Gertrude Strand, 2534 Northeast Twenty-fourth, Portland, Oreg.; Edward W. Roesbery, 1903 K Street, Tacoma-Emmett, Idaho; Nettie Dean, 3905 North Cheyenne, Tacoma, Wash.; Eunice Hitchcock, 1902 South Jay Street, Tacoma, Wash.; Fred S. Gibbs, 7425 South A, Tacoma, Wash.; Ina B. Baardson, Route 2, Box 14, Enumclair, Wash.; Grace E. Wolfe, 527 Alder Street, Shelton, Wash.; Melvin H. Wright, Orting, Wash.; C. A. Flanery, 5409 South M Street, Tacoma, Wash.; Mrs. Alice Meinert, Doute 1, Box 567, Auburn, Wash.; O. J. Rod, 1101½ South Twenty-third, Tacoma, Wash.; Mrs. Jack Del Guzzi, 931 East Eighth Street, Port Angeles, Wash.; Mrs. Dorothy Edwards, 718 East Scout Street, Port Angeles, Wash.; Romayne Doyle, Route 2, Box 207, Chehalis, Wash.; Mrs. Ralph Kohtz, Route 1, Eden. Idaho; Mrs. Geo. Kolano, 3621 East J Street, Tacoma, Wash.; H. Paska, 2518 Thirty-third Street, Seattle 44, Wash.; Ed S. Munson, 616 Fourth West, Seattle, Wash.; R. B. Davis, 3574 East M, Tacoma, Wash.; Beatrice Schamel, 528 South Fifth, Montesano, Wash.; Helen Althausen, 2721 East Ninetieth, Seattle, Wash.; Mrs. Cleo Peters, 617 South Jay Street, Tacoma, Wash.; Margaret Kropp, 1842 North Fifty-third, Seattle, Wash.; Miss Maggie Baird, R. N., Hazelton, Idaho; Cleo Krienke, Seattle, Wash.; Ernest O. Fox, 6030 South Pudget Sound, Tacoma, Wash.; Vida Giese, 4291 West Park, Bremerton, Wash.; Leone Warfield, 1922 South J Street, Tacoma, Wash.; Gladys Stanley, 3024 South A, Tacoma, Wash.; Prudence Freeman, 813 East Fifty-eighth, Tacoma, Wash.; Robert E. McClarin, 1211 South Fifty-sixth, Tacoma, Wash.; Mrs. R. E. Morrison, 1112 W. Shinn Street, Kent, Wash.; Mrs. R. W. Haanum, 1320 North Verde, Tacoma, Wash.; Mrs. Beatrice Larson, 834 East Eighty-fourth, Seattle, Wash.; Mrs. J. M. Gilbertson, 4622 North Verde, Tacoma, Wash.; Mrs. Lillian Evji, 4822 North Eighth, Issaquah, Wash.; Chas W. Palmer, 310 West Palmer, Compton, Calif.; Mrs. O. H. Judd, 3616 North Union, Tacoma, Wash.

Mr. **Fulton**. I would like for you to hear Mr. Keating.

STATEMENT OF HON. KENNETH B. KEATING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Mr. Chairman and members of the committee, I appreciate this opportunity to be heard in support of S. 102 and the various House bills which have been offered to provide for research regarding the cause, prevention, and treatment of multiple sclerosis.

It is reported to me that there are more than 1,000, perhaps as many as 2,000, victims of this baffling and obscure disease of the nervous system in my congressional district. Many of them and of their relatives and friends have written most appealing letters, setting forth sad cases where the sufferers from this malady, many of them in the prime of life, have been rendered virtually helpless. The disease is apparently progressive with varying degrees of speed. Prognosis of its course is almost impossible. It affects various members of the body intermittently, often jumping without warning from one part of the body to another. The victim finally becomes entirely helpless and bedridden. The course of the disease may run from just a few years to 20 or 30 years.

All efforts to determine the causes or satisfactory treatment by way of a cure have proved unavailing.

National health measures, particularly H. R. 4312 now before your committee, are highly controversial. Especially is that true of any provisions for compulsory health insurance.

Medical research, however, such as that envisioned within title II of H. R. 4312, is quite generally accepted as a field within which Federal aid is proper. Generally speaking, those who are violently opposed to the compulsory features of any health plan are in agreement that the health of people is a legitimate governmental concern and that grants-in-aid for the purpose of research into the cause, prevention, and methods of diagnosis and treatment of various diseases are entirely proper. Indeed, such programs are now in operation to a limited extent.

Great strides have been made by the medical profession in solving and conquering many diseases, resulting frequently in almost complete elimination. I feel sure the same will ultimately hold true regarding multiple sclerosis. To its present victims and their loved ones, however, time is an important element. The only way in which an early solution of the mysteries of this dread disease seems likely is through a vigorous and intensive research program financed with Federal funds.

No one knows where this disease may strike tomorrow. Everyone is a prospective victim.

Of course sufferers from poliomyelitis, diabetes, arthritis and rheumatism, cerebral palsy, epilepsy, and other obscure diseases are entitled to equivalent consideration given to the victims of multiple sclerosis. It is because of the great interest which has been aroused in this crippling and disabling malady and the large number of communications which I have received regarding it, that my interest in this important problem has been particularly aroused. There is another important reason for this interest which, with permission of the committee, I should like to discuss for a moment off the record.

Mr. Fulton. I would like for you to call Mr. Mansfield.

STATEMENT OF HON. MIKE MANSFIELD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MONTANA

Mr. Mansfield. Mr. Chairman and members of the committee, after listening to those who have preceded me, I can well understand the sympathies of this committee in their study of this particularly malady.

I did not know anything at all about multiple sclerosis until August of last year. At that time, Miss Jane Marie Sullivan, a reporter on the Butte Daily Post and a former student of mine at the University of Montana, called to my attention the situation concerning multiple sclerosis as it was then prevalent in the city of Butte, Mont. She informed me that in Butte alone, a city of approximately forty to forty-five thousand, there were over 100 cases of this dread disease; that there was no way by which these people could be treated; that the members of the medical profession were helping them in every way they could and also that they were in the process of forming a multiple sclerosis society to do what they could to take care of these unfortunate people.

It occurred to me at that time that it might be a good idea if something could be done through the United States Public Health Service to carry on research into this particular disease to see if some ways and means could not be found to alleviate the condition of these people. It also occurred to me—and this is not from a political standpoint—please understand me in that respect—that the place in which this research could be carried on would be at the Rocky Mountain Public Health Service Laboratory at Hamilton, Mont., where great work has been done in the field of cholera, yellow fever, Rocky Mountain spotted fever, and typhus, and where great advances have been made by the Public Health Service; but that is just an idea.

I contacted the Public Health Service. They do not know too much about this disease. They are very much interested and they would like to be of assistance.

It is my hope that the members of this committee will report out a bill dealing with research in multiple sclerosis, so that these people who are being, in the main, stricken down in the prime of their lives, may have an opportunity to be given every consideration by the Government of the United States.

I want to commend especially the people out in my part of the country for what they have done on a voluntary basis. In Butte, Mont., a small city, they have created a multiple sclerosis society. They have sought out contributions and they are now in the process of trying to hire someone who knows something about physical therapy so that in their own small way they can do what is possible for the victims of this malady.

Mr. Chairman, I would like to ask permission to insert in the record briefs of various letters and a statement which I have here concerning this deadly disease as it affects my particular part of the country.

Mr. PRIEST. That permission is granted.

Mr. Mansfield, I know that you have a very urgent appeal to attend another committee, but I just want to ask one question.

In title II of the omnibus bill there is a rather flexible provision and also in other bills, somewhat similar provisions, to enable the Public Health Service to establish institutes for research in a number of diseases, including multiple sclerosis, rheumatism, arthritis, cerebral palsy, and others.

There has been some discussion among the committee members of the possibility of establishing a neurological institute in which research could be done in a great many of these particular diseases.

In your opinion, would it be perhaps wiser to establish an omnibus institute rather than separate institutes to deal with each of these several diseases. I know you have studied the subject a great deal, and I would appreciate your opinion.

Mr. MANSFIELD. Well, personally, either a specialized institute or an omnibus institute would be satisfactory, in my opinion.

I dare say it would depend on conditions as to whether or not there should be any specific research centers created. The only thing I am interested in, Mr. Chairman, is to see that not only the victims of multiple sclerosis, but the victims of all these diseases are given every possible consideration and if it can be done better in a general institute, that would be fine.

Mr. PRIEST. Thank you very much.

Mr. MANSFIELD. Thank you, Mr. Chairman.

(The matter above referred to is as follows:)

Letter dated August 13, 1948, from Miss Jane Marie Sullivan, Butte, Mont., advising of the formation of a voluntary multiple sclerosis society in that city and the survey being made to determine the number of active cases in Butte and possibly other sections of the State. The need for vocational therapy is stressed as well as the desirability of research.

Letter dated September 21, 1948, from R. E. Dyer, director, National Institutes of Health, Federal Security Agency, in response to the interest of the Butte, Mont., group in problems of multiple sclerosis. Mr. Dyer states that the cause or causes of the disease are quite obscure, and, despite the scope of present investigations, little hope is held that a cure will be found in the near future. It is suggested that Mr. Leif Fredericks, director of the Montana Bureau of Vocational Education at Helena, be contacted with respect to rehabilitation services. The question of research is constantly being expanded by Federal funds and research grants-in-aid to other institutions.

Letter dated January 15, 1949, from Miss Jane Marie Sullivan, Butte, Mont., advising of the adoption of bylaws in which the Multiple Sclerosis Association of Montana is devoted to assistance of victims through the field of rehabilitation therapy. A copy of a master sheet of information which the workers will use as a guide in the membership drive is enclosed with the letter. (Master sheet is reprinted in full following listing of letters.)

Letter dated February 17, 1949, from Miss Jane Marie Sullivan, Butte, Mont., advising of the efforts of the association to obtain a therapist in order to establish a treatment center.

Letter dated February 15, 1949, from Mr. S. O. Meyer, attorney at law, Butte, Mont., advising of his interest in bill H. R. 2303, providing for research into cause and prevention of multiple sclerosis, and suggesting the possible solicitation of interest in support of the legislation.

Letter dated February 22, 1949, to Mr. S. O. Meyer, from the Honorable Mike Mansfield, acknowledging receipt of the former's letter and encouraging the need for support of the legislation concerning research in multiple sclerosis.

Letter dated May 12, 1949, from Mrs. Leland Powell, Helena, Mont., advising that she is a victim of multiple sclerosis and hoping for early passage of research legislation.

Letter dated May 16, 1949, to Mrs. Leland Powell, from the Honorable Mike Mansfield, acknowledging receipt of the former's letter, and advising that action is being taken toward early consideration of the legislation.

Letter dated February 27, 1949, from Mrs. William Lamers, Barber, Mont., advising of her interest in the multiple sclerosis legislation and hoping for early passage.

Letter dated March 3, 1949, to Mrs. William Lamers from the Honorable Mike Mansfield, acknowledging receipt of the former's letter, and advising that action is being taken toward early consideration of the legislation.

Letter dated February 26, 1949, from Mrs. Mary Leinenweber, Shawmut, Mont., advising of her interest in the multiple sclerosis legislation and hoping for early passage.

Letter dated March 3, 1949, to Mrs. Mary Leinenweber from the Honorable Mike Mansfield, acknowledging receipt of the former's letter, and advising that action is being taken toward early consideration of the legislation.

THE MULTIPLE SCLEROSIS SOCIETY OF MONTANA

We have attempted to briefly include in a bird's-eye view of multiple sclerosis, a few features of the symptoms and nature of the disease. In preparation our main object has been to make the slight amount of information readable and have tended far from the scientific views. No attempt has been made to discuss diagnosis. Much material of pathology and miscellaneous features has been purposely omitted.

Multiple sclerosis is a disease of the nervous system involving the nerves of the brain and spinal cord. It is assumed to be the second most common disease of the nervous system.

This disease is most commonly found in males or females between the ages of 20 and 40. It is important to realize then that it is a disease of young people in the prime of life. It has been reported in all ages from 1½ years to 80 years. It apparently is not an hereditary disease, thus cannot be transmitted to children. In the United States it is found most commonly in the Great Lakes region and the Northwest. It is relatively uncommon in the Southern States. The cause of multiple sclerosis is unknown, as is the case in many diseases, such as cancer, leukemias, many types of arthritis, etc. Much research has and is being done in this country to determine the cause of the disease.

From studies done on the nervous system of persons with multiple sclerosis much of the nature of the disease has been discovered. It has been found that plaques are found scattered throughout the brain and spinal cord. These plaques, when first forming, cause swelling of tissues around them, and if they persist destruction of tissue in and around them. This means, in essence, destruction of nerve supply to the muscle, or skin supplied by that nerve. Many areas may be affected. For example the muscles to the eyes, tongue, jaw, arms, legs, bladder, etc., or, by the same token, sensation to the skin or various parts of the body. Any one or a combination of the nerves supplying these areas may be altered, or destroyed causing dysfunction of the organ supplied. The number of organs or parts of the body affected, and degree that they are affected, thus depends upon the number of plaques, the size, amount of swelling of tissues around them, and length of time they have been present. It is important to realize that in early stages of the pathology the process is revesible, thus accounting for the transient features and frequently disappearance of sysmptoms in many cases of the disease.

The symptoms of multiple sclerosis are myriad, frequently transitory and rarely uniform. About all one can do is mention the most constant symptoms found in many patients and leave with the reader the understanding that any portion, all, or variations of the following features may be found in a case of multiple sclerosis. A patient may show:

1. Transient weakness, or stiffness of muscles of any limb—generally the arms. This may be present from month to permanent.
2. Dizziness, pain in muscles, difficulty in walking, trembling of hands, trouble with eyes and difficulty in talking.
3. Electric-like shocks throughout limbs or body.
4. Difficulty walking may result in staggering, falling to one or another side. Also in the arms, inability to control motion of one, or both arms.
5. Tremor (shaking, or trembling of hands) particularly when attempting to perform some work requiring attention of hands.
6. Difficulty in speaking may be noted in slow, halting speech with inability to pronounce some words.
7. Double vision.
8. Frequently tingling, or loss of sensation in various parts of body.
9. Disturbances with urination, or bladder function. In late cases of multiple sclerosis paralysis of various muscles of arms, legs, etc., frequently occurs and causes patient to become bedridden.

It is impossible in nonmedical terms to describe how multiple sclerosis may be diagnosed and differentiated from other diseases, but it will be assumed that a physician, with understanding of the above picture can establish a diagnosis.

Prognosis: The prognosis, or ultimate outcome in a case of multiple sclerosis is no more canstant than the symptoms of the disease.

Speaking generally, the average patient may find:

1. A remission early in the disease, lasting from 2 weeks to years.
2. Slow progressive changes characterizing the disease.
3. Life expectancy of from 3 years to 25 or more years.
4. Rather marked benefits from rehabilitation therapy if instituted early in the course of the disease (occupational therapy).

There are always cases that have rapid onset with early termination of life. By and large there are the same number of patients who may have one or two flare-ups of the disease, and remain well for a normal lifetime. These do not account for a high percentage of the total number of patients.

The cause of multiple sclerosis is not known—consequently any satisfactory treatment of the disease has not been forthcoming.

The principal objectives, therefore, are:

1. Recognition, on the part of the public, of the disease, its symptoms in an early stage, and outlook.
2. Establish through research, which is being carried on at centers throughout the United States and Europe, the cause of the disease.
3. Discovery, through research and therapeutic trials, of a cure for the disease.
4. Care of patients who have multiple sclerosis: (*a*) Through occupational therapy; (*b*) morale—through interest on part of public to find a cure.

The major factor in the care of a patient with multiple sclerosis, after diagnosis, is to keep him or her in a maximum state of mental and physical efficiency. This is important.

Mental: Interest and understanding on the part of the public as to nature, prognosis of the disease, interest in cure.

Physical: Occupation therapy.

In multiple sclerosis and other diseases similar, a weakened muscle may often be rejuvenated by constant organized exercise. When this is not possible there is a chance of training unused, uninvolved muscles to take over in place of muscles which can no longer be activated.

Occupational therapy: Therapy—curative; occupational—by means of occupation.

A therapist is trained to be equipped with a knowledge of interesting crafts, and the medical ability to prescribe these crafts in a way most likely to rejuvenate weakened muscles, or train unused muscles. The patient himself is taking an active part in this treatment; he is treating himself; the occupational therapist is his guide.

Occupational therapy treats multiple sclerosis, not as a cure, but as a means of arresting the progress of this disease, thereby keeping the patient active, keeping him physically and mentally alert, keeping him prepared for the day when cause and cure are discovered.

People in this State and this city should be interested because:

1. The disease is prevalent, roughly 100 cases in and about Butte.
2. It attacks young people.
3. Occupational therapy should be afforded the stricken.
4. Public spirit should include interest in any project which helps individuals overcome handicaps and become useful citizens.

Mr. PRIEST. You have some other witnesses, Mr. Fulton?

STATEMENT OF HON. JAMES G. FULTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA—Resumed

Mr. FULTON. Mr. Chairman, I interrupted myself in order that other Members of the House might make statements.

As to an omnibus neurological institute, it is practical if there could be some set-up under the statute to designate the particular type of disease upon which the research is being made, for example, on the multiple sclerosis, or on cerebral palsy, so that people could contribute, you will find a great public participation. If you just bulk them all under neurological diseases, I do not think you will get the public interest or participation. If within the institute there could be divisions, and if the committee could set up an arrangement whereby contributions could be made to those divisions maybe they would have an incentive. My bill provides that donations of $50,000 or over for carrying out the purposes of this title might be acknowledged by the establishment within the institute of suitable memorials to the donors.

Multiple sclerosis is coming to the public attention chiefly because of prominent people that have now been known to have the disease. It had not previously been publicly identified.

As you have heard, Mrs. Lou Gehrig testified before the Senate committee as to the disease that had really just killed Lou Gehrig, the iron man of baseball. It was a lateral sclerosis rather than multiple sclerosis, one of the rarer kinds, rather than multiple sclerosis.

In addition to that, Senator Tobey's daughter has it, as well as the wife of one of the Congressmen, who just testified, without naming the person.

Within my own group, this secretary of mine has suffered for 18 months—a young man that was in the north African campaign in the Navy, and in the Italian campaign; the brother of another chap that had worked for me that I have spoken of, Baldini Mucci had died of it.

In my district, there are many cases of it. Mine is the industrial southern part of Pittsburgh and there seems to be a peculiarity that it is especially prevalent in the Northern States of this country and especially in the industrial areas.

Another peculiarity is, in the industrial towns of Great Britain there is a great prevalence of it. On the other hand there is almost no multiple sclerosis, or any incidence of it, in China.

Now, since the war has finished, there are many thousand of cases that so far have been unidentified among young servicemen. They occur, it seems, to people subject to great strain or to climatic changes or to an industrial atmosphere that puts them under a strain even to exist.

The estimates of this disease and the incidence of it range from 300,000 to 500,000 in the country.

Now, in my district, in addition to the two cases I have known and have been interested in, I have heard of other cases. One family has two young people, one teen-ager and one in the twenties that have this disease and because they are a poor industrial family, they have pulled down the blinds, drawn into themselves, and they do not want to admit that there is progressive paralysis in the family.

There is no reason to hide it. It is one of those things for which to date there is no known cause, and it has nothing to do with venereal injection.

Sclerosis means a lesion and means a lesion of your basic nervous system, and multiple means many of them.

Now, in many cases what happens is that in your nerves to your spinal column there is a breaking and a bleeding. That lesion heals up and when it does it makes a scar tissue and from there on cuts the nerves. You know what happens to your muscles when you cut the nerves that control them and feed them. The muscles just go flabby.

Now, some of these people, with great difficulty through exercise can recover the use of some of their muscles.

Many people go blind when this scar tissue cuts the nerves to their eyes. Others lose the use of their whole body, and they gradually lose the use of everything until it gets to a vital organ and then they die.

The worst of it is that the treatment is all just around the outside edge, and these various institutes and the doctors that are studying on the cases can only study them superficially.

Now, there has been no severance of these cases. There has not been any attempt to put them into groups and to try to find the reason, in this civilization of ours, the people of the twenties and thirties, chiefly, are having a break-down of their central nervous system which kills them.

Under those circumstances, you can see it is beyond the power of any group or beyond the power of any particular agency to do the necessary research. We cannot have two doctors each working on one phase of this thing without a coordination over-all.

The reason the public should be interested in it is that from estimates doctors have given to me, this is twice as prevalent among youngsters, among the men serving in World War II, as infantile paralysis is. And the worst thing of it is that many of the cases are not identified and are not distinguished between paralysis, such as stroke paralysis and infantile paralysis and various kinds of multiple sclerosis.

You have had the bills on cerebral palsy and these bills fall in that same category; but if you want an explanation of the bill, I will be happy to answer any questions if the committee has any.

Mr. PRIEST. Are there any questions?

Mr. BENNETT. What does your bill provide as to the manner in which this research is to be carried out by the Federal Government?

Mr. FULTON. There is set up a National Multiple Sclerosis Council. It consists of the Surgeon General or his representative, the Chief Medical Officer of the Veterans' Administration or his representative, the Surgeon General of the Army or his representative, the Surgeon General of the Navy or his representative, the Chief of the Children's Bureau or her representative, and 12 members appointed without regard to the civil-service laws, by the Surgeon General, with the approval of the Federal Security Administrator, so that you have a council of 17, which should be 18. The bill does leave out the representative of the Air Force, and should have that included in any such council which is set up.

The Council will have the over-all supervision of the investigations. The Surgeon General is authorized to make grants-in-aid to States and to public and nonprofit institutions for the purpose of research.

The bill also provides that the Government should have the right in this Council to receive contributions from outside persons, private persons, and then designate what recognition shall be given to those over $50,000 by the establishment within the institute of suitable memorials to the donors.

Mr. BENNETT. Does your bill leave to the discretion of this Council the proportion of Federal funds as they see fit?

Mr. FULTON. No; it is the duty of the Surgeon General to do that, as it is in all of the other bills of this nature establishing foundations.

The duties of the Surgeon General in my bill are set out in section 704:

> (1) To conduct, assist, and foster researches, investigations, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of multiple sclerosis; (2) to promote the coordination of research, education, and control programs conducted by the institute, and similar programs conducted by other agencies, organizations, and individuals; (3) to make available research facilities of the Service to appropriate public authorities and to health officials and scientists engaged in special studies related to the purposes of this title; (4) to maike grants-in-aid to universities, hospitals, laboratories, and other public or private agencies and institutions, and to individuals, for research, education, and control—

and to make grants to other public and private agencies.

Mr. BENNETT. Under your bill, the Surgeon General can spend the entire amount through his agency, if he sees fit and make no grants to private institutions at all?

Mr. **Fulton**. Well, may I explain this to you.

On page 8 of my bill, under section 706 (b) it is provided:

> For each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum from the appropriation authorized under section 707 which shall be available for allotment among the several States and other institutions under this section.

So, actually, it is the Administrator, plus the Surgeon General, who makes the distributions.

Mr. **Bennett**. Well, one of the troublesome problems, it seems to me, on this question is whether you are going to pass legislation that will give the Surgeon General or the Public Health Service the power, if they want to use it, to ultimately put under Federal control all of the research activities for which Federal funds are appropriated, or whether the law should contain some limitation on the extent by which the Surgeon General may expand public-health facilities, as against the amount he may be required to allocate to private institutions of research to carry on this program.

Mr. **Fulton**. I think that that is a very good point and I think it is entirely within the purview of the committee to set up those rules and regulations that will govern the over-all policy of the distribution of funds.

As a Member of Congress, I had felt that it was wise to have this done, as much on a local level through grants-in-aid to States and already established institutions, as we could, rather than have it entirely centralized in a central bureau. I do feel, as you do, that there is the possibility of setting this limitation, maybe in your omnibus bill, for research of a neurological character that sets up the over-all policy. I do think that is a good point and could be taken care of.

I might make a comment from a statement of the Medical Society of the State of Pennsylvania, which calls this disease one of the most baffling and devastating diseases in existence in a circular that they have forwarded to all of the doctors and the Congressmen from our State.

Mr. **Biemiller**. Mr. Chairman.

Mr. **Priest**. Mr. Biemiller.

Mr. **Biemiller**. We have had several witnesses appear here to testify that they have been quite pleased by the manner in which the Cancer, the Mental Health Institute, the Heart Institute, and similar grants that have been made by the Congress heretofore have been administered.

Among those representatives was one from the American Medical Association, deans of medical schools, and others competent to give advice in this field.

I think we have to recognize in setting up any kind of a research that a great deal of flexibility is needed.

Mr. **Fulton**. That is right.

Mr. **Biemiller**. It seems to be the view of those who have previously testified that the best flexibility that has been achieved to date has been by leaving the ultimate power in the hands of the Surgeon General, subject to the approval by his senior officer, the Federal Security Administrator.

Those grants were made with the advice of the councils that have been set up on cancer, heart, and so forth. You have a similar provision in your bill, Mr. Fulton, and I think in view of the experience to date with the provisions heretofore set up that in your bill you were wise in following those provisions which have been worked out.

There has not been a single protest made to us about them. I do not believe that the fears expressed by Mr. Bennett would materialize.

If the Congress, on the other hand, is to start setting up a limit of 60 percent here, 30 percent there, and 10 percent somewhere else, we would quickly find ourselves in a situation where we would defeat the very purpose we are after. I want to compliment you for leaving the flexible provisions in your bill. I think it is the wisest way to take care of it.

Mr. FULTON. I feel that the policy should be flexible, but I can see if the committee wishes to direct it along certain lines, they could make rules and regulations under the policy. I agreed with Mr. Bennett as to certain rules and regulations, but I had not said that I felt that the over-all policy should be changed. So I do agree with you on the over-all policy, too.

Mr. PRIEST. Are there any further questions?

Mr. WILSON. Mr. Chairman.

Mr. PRIEST. Mr. Wilson.

Mr. WILSON. Mr. Fulton, when you resumed your testimony, a few moments ago, you spoke of, in response to the chairman's question, as to whether an omnibus institution or one separate institution should be set up, and you spoke along the lines of inducement of people to contribute.

I would like to hear you comment further along those lines. What are those inducements, and what would those inducements be?

Mr. FULTON. You have heard people here who feel so strongly about the disease, multiple sclerosis. You cannot believe what it is to have a diagnosis made within a family or an office group. When the possibility came to us in connection with this young man that has been working for me, that he had a broken neck plus a broken back, and had had it for a 2-year period without it being identified and was then so completely paralyzed that he could move no part of his body and could not turn in bed, and he could only breathe from the upper one-sixth of his lungs—when we heard it, there was general rejoicing in our office, because we were so beaten down with the fact that he had this progressive paralysis of which there is no cure or no possibility of cure. It is just a life sentence.

Now, in many cases these families have had people with multiple sclerosis—and a further personal reference, if you will pardon me—a friend of the housekeeper of my house in Pittsburgh has a situation where there is a man in his sixties that has had multiple sclerosis, and he has been confined in bed for 40 years without being able to move.

Those people are vitally interested because it has torn down the family life and makes the whole family center around this one individual that cannot move and can control none of his bodily functions.

So that it is very upsetting to the people around them and it makes a tragic case within a community, so much so because of the body odors and symptoms of that type, they often withdraw within themselves and hide themselves. It then becomes a secret thing.

Now, we who are trying to bring this out into the open before the public have backed the national movement, the Multiple Sclerosis Society organized by these victims themselves and their contributions of one, two, and five dollars. The public is catching on that it is such an extensive disease in these industrial communities, as shown by the number of letters which have been written to me from my district; it is amazing. And if the public finds that it is a worthy object of attention, such as infantile paralysis is, and such as cerebral palsy is, and finds that the rehabilitation will be much along the same lines, rehabilitating the nerves, the muscles, and getting them back into use again, then the public itself would want to help, and in order for them, the public, to help under section 707 (a) of my bill, I have said this:

GIFTS AND AUTHORIZATIONS

SEC. 707. (a) The Surgeon General shall recommend to the Administrator acceptance of conditional gifts, pursuant to section 501 of the Public Health Service Act, for study, investigation, or research into the cause, prevention, or methods of diagnosis or treatment of multiple sclerosis, or the acquisition of grounds or for the erection, equipment, or maintenance of premises, buildings, or equipment of the institute. Donations of $50,000 or over for carrying out the purposes of this title may be acknowledged by the establishment within the institute of suitable memorials to the donors.

(b) There are hereby authorized to be appropriated for each fiscal year such sums as the Congress may determine to be necessary to carry out the provisions of this title.

(c) Such appropriations as are hereafter made to carry out the purposes of this title may be expended in the District of Columbia for personal services, stenographic recordings and translating service, by contract if deemed necessary, without regard to section 3709 of the Revised Statutes; traveling expenses (including the expenses of attendance at meetings when specifically authorized by the Surgeon General); rental, supplies, and equipment, purchase and exchange of medical books, books of reference, directories, periodicals, newspapers, and press clippings; purchase, operation, and maintenance of motor-propelled passenger-carrying vehicles; printing and binding (in addition to that otherwise provided by law); and for all other necessary expenses in carrying out the provisions of this title.

The purpose of that provision is this: If, within your omnibus bill, or omnibus institute, if the committee should set up a multiple sclerosis division, or heart division, or infantile paralysis division, or cerebral palsy division, you will find that the research that they can interchange among themselves will be very valuable, because a lot of those diseases have to do with the basic central nervous system. Instead of possibly one little segment of the pie, the institute would do the over-all basic research and have these divisions set up so that the people particularly interested can say, "Each year I have faithfully contributed to the Multiple Sclerosis Institute, because I feel that it is necessary." I have been down here to the Kabat-Kaiser Institute on Sixteenth Street, and have seen the work that is being done there with these crippled young people from all over the country. So, I think you will find a great public response, and I think that the people, the public, should be permitted to participate and make private gifts.

Mr. WILSON. Mr. Fulton, I am asking these questions to get your reaction. I want to ask you another question along the line of another subject.

We have had these hearings going on for a good many weeks. Are there other inducements that might make the public catch on quicker, better, and stronger, and make for more substantial private contributions?

Mr. FULTON. If you will set a provision in your omnibus bill relating to multiple sclerosis, we can find the extent of these diseases and bring them out into the public eye and have some of these families pull the shades up—because they have taken it as a blight within the family. If we can do that, you will then sell the public the danger—and there is the danger that in this civilization of ours, the incidence of basic diseases to the central nervous system will finally destroy us. This animal nature of ours may be subject to such pressures in this world of ours—and it has happened in England because of the pressures that they were under—that if we do not go ahead and accept the challenge of this as a public thing that we will then find that the younger people of this country, just as it has been said, at the times when they should be the most productive, become the greatest drain on the country.

Does that answer your question?

Mr. WILSON. Yes. Thank you.

Mr. PRIEST. Mr. Fulton, we appreciate very much your statement before the committee and your answers to the questions, and your interest in the subject.

Mr. FULTON. May I finally close by saying this, it would be entirely satisfactory to me, and I think to the other sponsors if this were combined with cerebral palsy investigations and research, it will be satisfactory, because it is along the same line.

Mr. PRIEST. Thank you very much.

I believe that Mr. Weichel has come into the room. Do you desire to be heard, Congressman?

STATEMENT OF HON. ALVIN F. WEICHEL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Mr. WEICHEL. Yes, Mr. Chairman, I would appreciate saying a few words and include a statement.

I want to state some observations from my community. I personally have known of cases in my community for about 12 years. Most of the cases, as you have probably heard, have been of young people, probably under 35 years of age.

Now, those that I have known are such: The first case was a young man with a family. He was doctored generally in the community in this area between Cleveland and Toledo, for more than 2 years. Every doctor in the county not only looked him over and examined him, but they had him before the clinics in two of the principal hospitals in the county and they were able to make no diagnosis. Later they suggested going to the Cleveland clinic. He spent 2 days there, and that was the first diagnosis of multiple sclerosis in that area. I think that it was the second diagnosis they had made in the Cleveland clinic.

Now, this particular young man has a family and it seems that those with something to look forward to have lived a longer period of time than the others. He has gone on for some 12 years getting progressively worse. There was a time that he could feed himself. He has not been able to feed himself for 6 or 7 years.

There was a time that he could move with a cane. There was a time that he could move himself in a chair. He is now at the stage that even in a chair he is not able to move himself or anything, and for the last 3 or 4 years he lapses into a state of unconsciousness for a period of a couple of hours to a day.

There is no treatment of any kind that they recommend. They have tried everything that they know.

This one person has been able, it seems, to survive by sheer will power and the use of certain types of vitamins which just about keep him alive.

Well, as to the aids for it, you get some aid from the county health department. The doctors probably make no charge, because they are not able to accomplish anything. And this one person has survived these 12 years. He has two children.

But I have seen four cases that were diagnosed since that time, of younger people in their twenties, and every one of them died within a year or two.

As Congressman Fulton has said, they seem to feel some sort of a complex with reference to it, so that they will go to bed and see nobody and just die.

I have observed these cases personally, about a half a dozen of them, over a period of the last 12 years, and those people are absolutely without hope. Money does not help in connection with any treatment. The doctors have no interest in it. They just throw up their hands and say, "There is nothing we can do."

I can remember this young man had multiple sclerosis. There was no diagnosis for the first 2 years. After diagnosis was made, the physicians in the clinic wrote to his family physician, and the young man did not know what he had. They said he had total disability. Well, like a lot of people with an insurance policy, he went to his physician and they had a certification made with reference to no further payments on his insurance, so that was the first time he knew that he had multiple sclerosis. Well it did not mean a thing to him until about 2 years later—and the members of the committee might remember that there was great publicity given to the case of a girl in California, where she had been given a diagnosis of multiple sclerosis and they had said that she had a year to live. She was picturized and the story went all over the country in the daily press, and when this young man read the story about multiple sclerosis and what it meant, immediately his condition dropped down 50 percent or more. But, up until that time, when he did not know what it was, he stayed in high spirits with the idea that he might get well. After reading the publicity and knowing what he had, why, you could see what effect it had.

So that I concur in what Congressman Fulton has said, and I know that he has had a very, very special interest, since here in Congress. I knew the young man who was in his office.

I commend this committee in being so patient listening to the various details of this terrible disease.

I thank you.

Mr. Priest. We thank you very much, Mr. Weichel. We appreciate your interest in the subject.

(The statement submitted by Mr. Weichel is as follows:)

Statement of A. F. Weichel of Ohio

MULTIPLE SCLEROSIS

Mr. Chairman, I have introduced a bill which I hope may be a step in helping to some day solve one of the mysteries still baffling modern medical science as it has baffled medical men since it was first identified 80 years ago by a neurologist.

The disease is one which respects no one. It is a disease which attacks the healthy. At one time so little was known about it that it was considered so fatal that little or nothing was done by scientists to investigate the cause and cure. At least 80 percent of those affected by the disease become helpless invalids within 5 years.

With an estimated quarter of a million of our people in the United States afflicited by this crippling disease termed multiple sclerosis (sometimes referred to as Charcot's disease), people who might otherwise have lived useful and happy lives with their loved ones are doomed to helplessness; they become helpless cripples, wasting away as this disease wrecks their bodies and yet we are powerless as we stand by and unable to cure these sufferers.

With all our great advancements in the sciences, it is my belief that we have the know-how, the brains, and facilities to combat this scourge. By properly focusing the sights of medical science upon the disease to coordinate and evaluate findings and results of the research contemplated in such legislation we can some day hope to fortify our medical practitioners throughout the country with the necessary knowledge and help an estimated quarter of a million afflicted people to lead useful lives again and to prevent such occurrences in untold millions more in the future.

Mr. Priest. If there are no objections, at this point in the record, the Chair would like to submit a brief statement from our colleague, Mr. Buchanan, of Pennsylvania, and state also that other members of the House have sponsored legislation on this subject and they without objection could submit statements for the record.

(Statements of Mr. Buchanan, Mr. Javits, and Mr. Ford are as follows:)

House of Representatives,
Washington, D. C., June 22, 1949.

Re multiple sclerosis.

Hon. J. Percy Priest,
Chairman of Subcommittee on Public Health, Science and Commerce of the Committee on Interstate and Foreign Commerce.

My Dear Mr. Chairman and Members of the Committee: I am, as I am sure all Members of Congress are, interested in seeing that appropriate legislation is passed by the Congress to amend the Public Health Service Act, to provide for research and investigation, with respect to the cause, prevention, and treatment of multiple sclerosis.

Multiple sclerosis is one of the diseases affecting the health of the Nation and constitutes a still unsolved problem. Thousands of our citizens are stricken each year with this dreaded disease, and do not realize what is happening until they become helpless invalids.

Immediate steps should be taken by our Federal Government to provide for research and investigation with respect to diseases of the central nervous system to develop more effective means of prevention, diagnosis, and treatment of such diseases and injuries to cure the victims thereof.

Medical science, to date, has not been able to offer much in the way of aiding, diagnosing, or recommending proper treatment of those affected by multiple sclerosis. It strikes, as we all know, persons in apparent perfect health, and thousands of individuals in the prime of life die yearly from this dreaded disease because medical science has not been able, because of lack of properly trained scientists to make a study of the causes, or suggest treatment for those afflicted by this disease.

I am most happy to see that the committee, is at this time, considering the bills referred to it on this subject and trust that the bill introduced by me, H. R. 1315, will be favorably considered. I am sure the committee realizes the seriousness of this disease and will favorably recommend appropriate legislation in this respect.

Sincerely,

Frank Buchanan, M. C.

Statement of Hon. Jacob K. Javits in Support of H. R. 1375

Multiple sclerosis, a chronic disease of the central nervous system which thrives in cold, damp climates, chiefly finds its victims among the young people of our Nation whom it cripples without regard to social or economic position.

For multiple sclerosis is a plague for which no wonder drug has yet been found and for which no definite cure is known. A relatively unknown disease, there is no agreement among neurologists as to its cause and hence no specific treatment for its cure which is generally accepted. Little, if any, important progress has been made since multiple sclerosis was first discovered 80 years ago by the French neurologist, Jean Martin Charcot.

Because of the ignorance surrounding it, few physicians are trained even to recognize this ailment which cripples twice as many people as does infantile paralysis (in 1948 $18,669,299 was allocated for infantile paralysis research). This ignorance makes multiple sclerosis still more dangerous. There is a scarcity of statistical records from which studies might be made. There are no endowed hospital beds for treatment. There are but three diagnostic clinics in the entire United States, where physicians may send patients for check-ups by specialists (New York, Boston, and Albany—none west of New York State or south of New York City). The almost complete lack of research funds makes this disease a major medical problem for our physicians and the long, expensive hospitalization now required makes it a major problem for the families of its victims and our citizenry.

To think that a loved one, well and healthy today, may within a matter of one or two days be cruelly crippled by a disease about which so little is known that even its cause remains obscure let alone its treatment and cure, should sober us to the realization that congressional recognition of the necessity of research and investigation to develop more effective means of prevention, diagnosis and treatment is necessary. The National Multiple Sclerosis Act (H. R. 1375) which I proposed on January 13, 1949, acknowledges this responsibility by making possible the necessary researches and training of personnel which will bring this crippler out of the darkness into the light where it may be fought and conquered. The legislation follows the pattern pioneered so successfully by heart disease and cancer research.

STATEMENT OF HON. GERALD R. FORD, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman, I am Gerald R. Ford, Jr., Representative from the Fifth District of Michigan, and in appearing before the Subcommittee on Public Health, Science, and Commerce of the Committee on Interstate and Foreign Commerce I wish to make this statement in behalf of my bill, H. R. 1645, and the other bills pertaining to the same subject. It is my understanding that 16 other Members of the House have introduced nearly identical bills which seek to amend the Public Health Service Act in order to provide for research and investigation with respect to the cause, prevention and treatment of multiple sclerosis.

We are all familiar with the unfortunate and untimely death of the immortal Lou Gehrig who died of this disease. Few, however, realize that there are vast numbers who have suffered in obscurity the same fate. Unfortunately it is becoming a rather wide-spread disease and according to the Michigan chapter of the National Multiple Sclerosis Society approximately 2,500 to 3,000 persons in the State of Michigan are victims at the present time. I am further informed by the Public Health Service that in 1947 1,527 persons died of this dread disease. The death rate in 1947 per 100,000 was 1.1.

After talking with those who are affected, reading their letters, and seeing the facts and figures as to what this disease does to human beings, one cannot resist doing everything possible to achieve relief for those unfortunate people. I hope the subcommittee and the full committee will take favorable action without delay.

Mr. PRIEST. The Chair feels that it is necessary and that we would like to have a medical authority as a witness at this time. Is Dr. Traeger here?

Dr. TRAEGER. Yes, sir; Mr. Chairman.

Mr. PRIEST. Dr. Traeger, we will be glad to hear you.

STATEMENT OF DR. C. H. TRAEGER, NEW YORK, N. Y.

Dr. Traeger. Mr. Chairman and members of the committee, this is a little reversal of the other hearing, where I was the last man.

Mr. Priest. Doctor, we have had a number of statements from laymen and we want some medical authority, so we will call you as our next witness. We are very happy to have you, here, sir.

Dr. Traeger. Thank you.

Now, the question of prevalence in multiple sclerosis is one which has been bandied about for a great many years. To be sure, it is a job of the Surgeon General's office to determine the incidence, the morbidity, mortality, and geographic distribution of the various diseases. However, there apparently have never been any funds available in the Surgeon General's Office or in the Public Health Service for this job.

Our little society, the National Multiple Sclerosis Society has never had more than $200,000 in the bank in any 1 year since its inception a little over 3 years ago. But it is spending $25,000 of its limited funds to determine just those answers: The prevalence of the disease; geographic distribution; climatological influence and racial influences You have heard from a previous witness that one town, Butte, Mont., has a hundred cases.

Several years ago we sent out a questionnaire in the Greater New York area asking the doctors to send us a report of the number of cases of multiple sclerosis they have. Well, only 5 percent of those cards were returned. Yet, out of those 5 percent, we found over 5,000 cases of multiple sclerosis.

The survey which is now being conducted and financed in part by the Multiple Sclerosis Society is about half way past its completion. At the meeting of our medical advisory board 2 weeks ago, Dr. Kolb, of the Public Health Service, told us that we would be amazed when the survey is finished; that the prevalence of this disease is much greater than anybody has suspected.

Now, when you talk of prevalence, you have to remember that the statistics comprise only the known cases; only diagnosed cases; only the cases that have come to the attention of doctors or hospitals. How many more sufferers there are who have been misdiagnosed or not diagnosed at all or who have not come to the attention of the medical statisticians, we do not know; but it will probably be fantastic.

You have also heard that the age incidence of the disease falls into the productive age groups, between 18 and 40.

It is found in children, not too uncommonly, and it is found in older people.

The peculiarity of the disease is that, when it strikes, it involves not only the patient but somebody has to take care of the patient. Very frequently, the patient has just started a family or has just graduated from law school or just come out of medical school, or has just started a business. The whole social and economic structure of that patient is destroyed immediately. He not only fails to become a breadwinner, a social, economic unit, but he becomes a liability—a physical liability, and a social liability. Somebody else has to take over the job of earning the daily bread and somebody else has to take over the job of caring for the patient, because they cannot eat; they cannot comb their hair; they cannot go to the bathroom;

they cannot perform just the ordinary functions of the business of living.

Now, you would be quite right in asking the question: "Why do not hospitals take care of these people?"

Do you know, gentlemen, that there are many hospitals in the United States which have a specific ruling against the admission of multiple sclerotics. They just will not admit them. Now, why? They won't admit them because they don't know what to do for them and they don't know what to do with them and if they admitted multiple sclerotics, they would have no beds for anybody else.

Every once in a while some "lucky" (?) sufferer of this disease gets admitted to a hospital and they putter with them and they try this, that, and the other, and then he is discharged. And discharged to what? To home care, which is inadequate, and sometimes even disastrous.

There are no adequate nursing care facilities to care for these people after they are discharged from the hospitals.

The commissioner for chronic illness came to me and said, "What are you doing about your multiple sclerotics? How are you managing for their custodial care?" The answer is, we are not, because we do not have the facilities.

Now, I leave it to some of my other medical friends and colleagues to give you the details of the pathology of the disease and the physiological and anatomical effects, but I want to talk to you about other aspects of this disease.

There is a great need for research in the diseases which include amyotropic lateral sclerosis and other dimyelinating diseases.

The research must begin as basic research. We have got to be able to understand the building blocks of the nervous system; the physics of the nervous system; the chemistry of the cells; the manner in which the disease affects the nervous system and how it spreads and why occasionally the disease stops completely and the symptoms disappear only to recur again at a future date, with increased severity and greater ravages.

Besides basic research, there is a tremendous need for clinical research in methods of the amelioration of the disease.

These people are sick; they are paralyzed, and they are dying.

Now, it is all right to have erudite citizens in laboratories spend their time to try to find the cause of the disease but that is not helping the sick patient. We ought to be able to find something that will help him to bear his cross while the scientists are finding the cause.

True, there have been many treatments advocated. The other day one of our leading neurologists sent me a memorandum on the drugs used in multiple sclerosis—some 20—and I was very discouraged, because, apparently none of them have proven scientifically to be really adequate.

There need to be clinics throughout the United States.

Our organization, as small and as poor as it is, supported by nickels and dimes from multiple sclerosis sufferers supports in great part two clinics, and we are starting another one. We have one clinic in Boston, one in Albany, which is now being transferred to the Montefiore Hospital in New York. Before the end of the year, we hope to finance a new clinic connected with the New York University, Bellevue Hospital. We are a poor organization. It took us over a year to dig up

$80,000 to support the New York Bellevue clinic, and that is not a great deal of money, gentlemen.

Now, you have also heard the fact that many of these patients have been diagnosed incorrectly, or not diagnosed at all.

The need for funds includes the development of fellowships and refresher courses for doctors. Unless young students out of medical school are given the opportunity to become familiar with the details of this disease and unless practicing physicians are given the opportunity to become familiar with this disease, we shall go on misdiagnosing them and going on mistreating them.

Now, why is it that we are here? In the first place, the Infantile Paralysis Foundation and the Heart Foundation and the Cancer Foundation have had adequate public support and goodness knows, adequate Government support, for their activities. They are entitled to them and they have our blessings; but we are faced with an entirely different problem. In the first place, we have a disease which has a difficult name to pronounce. When you say that a person has multiple sclerosis, people will say, "Why, what does that mean?" They never heard of it. And, as you have heard this morning and you have heard from Senator Tobey, they never heard of the disease until it struck their family or the families of their friends.

Now, the reasons that people support voluntary health agencies, the reasons that the public gives funds, are easy to understand. If you present them with an appeal for funds with respect to a disease that has a fatal outcome, they will pay, they will give. Cancer is a typical example of that kind of a disease. Everybody is scared that maybe they will get cancer, because so many other people have gotten cancer. "Cancer is a fatal disease, and maybe if I give my $5 or $10, maybe somebody will find out how to prevent me from getting cancer."

Another reason that people give funds for medical research is if the disease is a contagious disease. Tuberculosis is a typical example of that sort of thing. You are working in a factory or you are working in an office and a man at the next bench or the next desk has tuberculosis. You know that you might be the next victim, you might catch it from him.

The public will give money to devise ways and means of preventing the contagion of the disease.

The third reason for people giving money for research is the dramatic appeal—children's diseases. Polio is typically a children's disease. Rheumatic fever is typically a child's disease. It pulls on the heart strings. Rheumatic fever hits with a bang. Polio hits with a bang. The dramatic appeal of the sick, suddenly stricken child, is an important one.

The fourth reason for people giving money is numbers. Sure, there are 8,000,000 arthritics and everybody knows about arthritis. You do not have to explain arthritis, and we know about it, and people will give.

But people will not give for multiple sclerosis because they do not know about the disease. It does not strike with tremendous suddenness, it does not have the drama, it is not a contagious disease, and people do not die of it right away.

The Multiple Sclerosis Society has become the center of information about the disease. I get letters from doctors all over the world. I get letters from the directors of the vocational and rehabilitation bureaus, from the Veterans' Administration, from the Navy, asking me for policy—"What shall we do with these patients that have multiple sclerosis? What are their potentials for rehabilitation?"

They all look to us for guidance. We have got to give them an answer sometime. The only answer we can give them is to have enough funds to buy enough brains to get those answers.

We have had in the past, through the Government agencies, about $20,000,000 appropriated for 1,762 grants in scientific research. Of those 1,762 grants, only 20 were in the field of neurology.

Of 467 fellowships in research, only 2 were in the field of neurology, and none of it for multiple sclerosis.

Gentlemen, the world is looking to us for the answer. We can give you the answer if you implement our efforts.

Thank you.

Mr. Priest. Doctor, we thank you very much. Are there any questions? If not, thank you very much for a very complete and informative statement, Doctor.

Dr. Traeger. Thank you.

Mr. Priest. May the Chair announce at this point that it will be necessary for this subcommittee to go into recess at 20 minutes to 12 because of a meeting of the full committee in this room.

We hope to go back into session at 12:15 and clear all of our witnesses, if we possibly can.

We will have to go to the floor a little later than that for a roll call, so we will proceed as expeditiously as we can.

Mr. Priest. Our next witness will be Mr. Carl M. Owen.

Mr. Owen, will you proceed, please?

STATEMENT OF CARL M. OWEN, CHAIRMAN OF THE BOARD OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY, NEW YORK, N. Y.

Mr. Owen. Mr. Chairman and members of the committee, most of what I have included in my prepared statement has already been given much more graphically than I could possibly give it, so I see no point in repeating it.

Mr. Priest. Very well. Will you give your full identification for the reporter?

Mr. Owen. I happen to be chairman of the board of the National Multiple Sclerosis Society, and on their behalf I am here.

Mr. Biemiller. You were also a law partner of Wendell Willkie, were you not?

Mr. Owen. That is right.

I became interested in this disease about 3 years ago, and like so many men, had never heard of it before. A client of mine had a very beautiful daughter who was tragically crippled with the disease. He sought to enlist my interest, to get the aid of the Infantile Paralysis Foundation to help out in the activity of the little society which Miss Lawry, sitting here, had just organized.

The more I looked into the matter, the more it caught my heartstrings, and I little by little became more interested in multiple sclerosis than I did in law. Today I am giving more time to multiple sclerosis than I am giving to law.

It is an intensely appealing field, and it is a very tragic situation and requires some help somewhere.

I just want to tell you of one little incident with regard to this matter of diagnosis.

Mr. Buckley, the head of the Bell Telephone Laboratories, is on our board of directors. He is, I presume, the outstanding physicist in the United States, on electronics. He told me that it was not until he read an article that we had caused to be put in some magazine that he became aware as a layman that a member of his fmily might hve been suffering from multiple sclerosis for almost 5 years, although the victim had been sent to this doctor and that doctor and other doctors to find out what the trouble was.

The diagnosis is missed in so many cases. There is only one part of the prepared statement that I would like to read to you, which I do not think has been entirely covered by the testimony of the previous witnesses. I am reading now:

The fact that this disease is not epidemic and therefore does not—like infantile paralysis—create an occasional national scare; the fact that the families of the victims are impoverished by the disease; the fact that the existence of the disease is so frequently concealed from the victim and his family (and you have heard, and our files are filled with thousands and thousands of letters, pathetic letters, from people where the family who are in comfortable circumstances are almost at the door of penury because of the impoverishment caused by this disease) and we could give you hundreds and hundreds of cases in our files where contributions are made by outsiders, but "Don't let the family know" or the father makes the contribution, but "Don't let my family know"—very important people—"Don't let the family know, don't let the victim know," thousands of cases—all of these and other considerations which Congressman Fulton emphasized, make it difficult to raise sums of money sufficiently adequate for the private support of projects to attack this fundamental problem.

As will be more fully disclosed in the testimony of other witnesses, some of the basic research already instituted under the auspices of the society, indicates that in solving the cause of multiple sclerosis we may find the fundamental cause of many diseases not even related to the nervous system.

The same type of pathological phenomenon which destroys nerve cells in multiple sclerosis may be the source of the trouble in many chronic diseases.

Multiple sclerosis, while the most important, is only one of a number of diseases of the central nervous system resulting in a destruction of the myelin sheath of the nerves or other similar nerve degeneration.

A related disease is amyotrophic lateral sclerosis, the disease that killed the great ballplayer, Lou Gehrig. This disease has become known as the Lou Gehrig disease.

Under the leadership of his widow, a memorial fund is now being created known as the Lou Gehrig memorial fund, for the purpose of aiding the activities of the National Multiple Sclerosis Society.

Dr. Hans Hoff, neurologist on the staff of Neurological Institute of New York, presented a report to the society on all diseases which might benefit from basic research in the field of multiple sclerosis.

Mr. Chairman, I have two pages of diseases here of a kindred nature, some with names that I cannot even pronounce myself. I will not take the time of the committee to read them but you will find them in my statement.

Parkinson's disease, about which we know more—the paralysis which causes the person to stumble and fall—is a related disease.

While the Public Health Service is conducting investigations into the cause and cure of infantile paralysis and into matters of mental health, there is, I believe, no research under way, either private or public, into these devastating diseases which is in any way commensurate with the magnitude of the problem involved, and its public interest.

We respectfully submit that the establishment of a neurological institute under the aegis of the Public Health Service is well worthy of congressional support.

In passing, I might say that it should be borne in mind that surveys indicate 65 percent of the people receiving relief are chronically ill.

For the sake of economy, it might well be a good policy to attack the root of their illness rather than to have them constantly on relief.

On behalf of the 15,000 members of our society, their relatives and friends, we earnestly urge that the pending bill should receive your approval.

I thank you.

Mr. PRIEST. Mr. Owen, do you have any knowledge of how many clinics or hospitals in the country today are doing any special research in multiple sclerosis?

Mr. OWEN. There are two that we are supporting. There is this clinic in Tacoma, which is conducting some research. Have you established yours in California, Dr. Putnam?

Dr. PUTNAM. Not formally.

Mr. OWEN. I think that is about the limit of clinics. We have under way six or seven small projects that we are supporting as best we can. We are a very small "little baby" and find it very difficult to live these days.

But as far as clinics are concerned, as Dr. Traeger says, it is very difficult to get the hospitals to take these patients, because they just become a burden on them.

Mr. PRIEST. Are there any other questions? If not, we thank you, Mr. Owen.

Your statement in full will be included in the record at this point.

(The statement is as follows:)

TESTIMONY OF CARL M. OWEN AT HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE INTERSTATE AND FOREIGN COMMERCE COMMITTEE

I appear before you as the chairman of the National Multiple Sclerosis Society, a charitable foundation established under the laws of the State of New York for the purpose of investigating the cause of, treatment of, and a possible cure for the dread disease multiple sclerosis.

I thank the members of this distinguished committee of Congress for permitting me to testify in support of comprehensive public aid to the victims of that disease.

I am going to assume, probably in error, that most of the committee are as ignorant of this disease as I was 3 years ago when a client of mine whose beautiful daughter, badly crippled thereby, sought my aid in connection with the building up of the activities of the National Multiple Sclerosis Society. Many people know of the disease, which they describe as creeping paralysis. Very few know of it under the name of multiple sclerosis. The word "sclerosis" means hardening, and the disease as its name indicates, results in live nerve cells in the brain and spinal cord being replaced by scarred or hardened cells. And since this replacement occurs in a number of places, the word "multiple" is used. Multiple sclerosis is a disease of the central nervous system. The symptoms of multiple sclerosis are present in almost every part of the body resulting in widespread discomfort and suffering to the victim. The symptoms vary with the part of the nervous system involved, but the following are some of the most common ones found: Disturbance of vision such as double vision; tremors of parts of the body (involuntary quivering); nystagmus (involuntary movement of the eyeball); weakness; difficulty in walking and balancing oneself; numbness of parts of the body such as the legs; speech difficulties; emotional disturbances; bladder trouble. Thus, while most diseases are limited to one or a few symptoms, the ravages of multiple sclerosis know no limitations.

Multiple sclerosis may strike suddenly. Symptoms may develop within a few moments or over night. Or the onset may be subacute and gradual, increasing over days. Occasionally an acute attack will reach a fatal outcome swiftly. Usually the symptoms are slowly progressive and the patient becomes increasingly more and more helpless.

Multiple sclerosis is treacherous. Remissions may occur, in which the symptoms improve or disappear and the patient apparently recovers. But this does not mean that he is cured. Relapses occur frequently. As relapses recur, symptoms intensify and new symptoms develop, rendering the patient more and more helpless.

Multiple sclerosis usually strikes between the ages of 20 and 45, although it has occurred in adolescents and older people. It is a disease of the young adult, attacking him during his most productive period and when he has assumed family responsibilities. In many cases the victim becomes incapacitated, without the means of earning a livelihood, a heavy burden on his family, eventually perhaps dependent on the community.

Thus, multiple sclerosis is a serious social menace that concerns everyone in the community, whether or not he is a sufferer. One of the greatest difficulties that confront us is the lack of adequate statistical information. Since the beginnings of the work of the National Multiple Sclerosis Society, in October 1946 (extremely limited and ineffective at first and still very limited), it has become increasingly clear to the medical profession and to the society that the number of people afflicted with multiple sclerosis alone, irrespective of the number of people afflicted with kindred neurological disorders, is many times greater than there had been any conception of. Neurologists and physicians generally are in accord that the diagnosis of the disease is missed in at least 50 percent of the cases. It is certain that many persons who are suffering from what seemed to be disorders of the eye, disorders of the urinary system, disorders of muscular coordination, etc., are in fact victims of multiple sclerosis or related neurological diseases and continue to be such victims without the exact nature of their disease having been diagnosed until the disease has progressed to a very marked state. For example, on the board of directors of the National Multiple Sclerosis Society is one of the outstanding scientists of the country. His brilliant, athletic son, now in his twenties, has multiple sclerosis. It was not until the father read an article published at the instance of the society that it dawned on him—a layman—that what his son had been suffering from for over 5 years, intermittently but with increasing damage, was in fact multiple sclerosis.

The standards of diagnosis have not been known to the doctors—even to the neurologists—and were not readily ascertainable until the publication by the National Multiple Sclerosis Society of a brochure about a year and a half ago giving the minimum standards.

Further difficulty is encountered due to the fact that multiple sclerosis is not a reportable disease. Another obstacle arises from the fact that hospitals are reluctant to, and in many cases refuse, to receive multiple-sclerosis patients. They know that they can do nothing for the patient and that their much-needed space may be occupied by the patient indefinitely without benefit either to the patient or to the hospital.

All these factors and others make it quite hard to get anything like accurate statistics with respect to the prevalence of the disease.

The statistics that are available would indicate the probability that there are at least 250,000 people in the United States who are victims of multiple sclerosis alone. How many more are victims of the disease which killed Lou Gehrig, the "iron man of baseball," we do not know. How many more there are of many other related neurological diseases we do not know.

That the disease is by no means a rare disease is indicated by the fact that in one county of Connecticut alone no fewer than 56 cases were discovered in a population of 30,000. I repeat, were discovered. It is safe to assume that there were at least 50 percent more cases of multiple sclerosis—or some related disease—not discovered.

One of the difficulties in connection with statistical information arises from the fact that the cause of multiple sclerosis and other kindred diseases is not known and that there is no known cure therefor. Further, there is no present method of giving substantial alleviation to those who are suffering from its crippling attacks. Consequently, the mental and emotional state of those who know that they have the disease is pitiful, since they are aware that they have become or are bound to become a burden on their family, in many cases unsupportable, and that they are bound to be progressively incapacitated and ultimately bedridden, if not actually killed, by the disease.

An interesting phase of the disease is that the mind of the victim often remains perfectly clear and apparently unimpaired organically. So, with mental faculties still on the alert, the victim confronts a hopeless future. In consequence of this situation, doctors are loath to inform the victim or his family of the fact that he has the disease. He is frequently told that he has something else. In addition, the experience of our society has shown that, due to the above factors, and perhaps to the natural reluctance of doctors to disclose confidential information, and in part due to the fact that they are busy men, it is very difficult to get physicians to give to the society such information as they actually have with respect to the number of multiple-sclerosis patients they have treated.

A sort of spot-check survey is now being undertaken in certain key cities of the United States as the result of a grant made by the National Multiple Sclerosis Society, which seems to indicate on the basis of preliminary figures that there are in the neighborhood of at least 100,000 cases in the United States. We believe that that figure is entirely too low.

The effect of the disease on the family of the victim is more often than not disastrous. Our files are filled with the pathetic reports of thousands upon thousands of people who have been reduced to a state of practical penury as the result of the father or mother or the son or daughter or the husband or the wife coming down with the disease.

The fact that the disease is not epidemic and therefore does not (like infantile paralysis) create an occasional national scare; the fact that the families of the victims are impoverished by the disease; the fact that the existence of the disease is so frequently concealed from the victim and his family—all of these and other considerations make it difficult to raise any sums of money at all adequate for the private support of projects to attack this fundamental problem.

As will more fully be disclosed in the testimony of other witnesses, some of the basic research already instituted under the auspices of the society, indicates that in solving the cause of multiple sclerosis we may find the fundamental cause of many diseases not even related to the nervous system. The same type of pathological phenomenon which destroys nerve cells in multiple sclerosis may be the source of the trouble in many other chronic diseases.

Multiple sclerosis, while the most important, is only one of a number of diseases of the central nervous system resulting in a destruction of the myelin sheath of the nerves or other similar nerve degeneration. A related disease is amyotrophic lateral sclerosis, the disease that killed the great ball player, Lou Gehrig. This disease has become known as the Lou Gehrig disease. Under the leadership of his widow, a memorial fund is now being created known as the Lou Gehrig Memorial Fund, for the purpose of aiding the activities of the National Multiple Sclerosis Society.

Dr. Hans Hoff, neurologist on the staff of Neurological Institute of New York, presented a report to the society on all diseases which might benefit from basic research in the field of multiple sclerosis, as follows:

1. Diseases related to or even identical with multiple sclerosis: (*a*) Acute multiple sclerosis, (*b*) neuromyelitis optica (Devic), (*c*) Schilder's disease, (*d*) subacute necrotic myelitis (Foix and Alajouanine).

2. Diseases of a degenerative inhereditary basis which lead to a demyelination of the axones: (*a*) Krabbe's disease, (*b*) Pelizaeus-Marbacha's disease, (*c*) Scholz disease, (*d*) Ferraro diseases.

It is likely that in the above diseases, enzymes which play an important part in the myelinization are not formed properly.

3. Diseases in which avitaminosis leads to changes of the myelin sheaths and the axones: (*a*) Secondary combined degeneration in pernicious anemia, (*b*) Marchiafave-Bignami's disease, (*c*) Lathyrosis.

4. Diseases which lead to perivascular myoclasis. These diseases partially form the group of leucencephalitis: (*a*) Measle encephalitis, (*b*) scarlet fever encephalitis, (*c*) vaccinia encephalitis, (*d*) small pox encephalitis, (*e*) Encephali-

tis following mumps, (*f*) encephalitis following virus pneumonia and other respiratory diseases.

5. Multiple sclerosis research should embody a virus investigation. From this research all virus diseases of the brain will benefit: (*a*) St. Louis encephalitis, (*b*) encephalitis B, (*c*) encephalitis Japonica, (*d*) equine encephalitis.

These encephalitides infect all the brain and cause lesions quite similar to multiple sclerosis in the white substance of the brain.

6. Research in allergic mechanisms of multiple sclerosis will clarify the still unknown mechanisms in all infections of the brain, especially: (*a*) Myelitis after rabies inoculation, (*b*) in arsenic encephalitis and other toxic encephalitides, (*c*) in some forms of migraine and epilepsy.

7. The attempt to treat signs of multiple sclerosis like spasticity and cerebellar signs will benefit all patients who suffer from: (*a*) Spastic symptoms such as infantile spastic paraplegia and infantile cerebral palsy, (*b*) cerebellar degenerative diseases, such as Friedreich's disease, heredo-ataxia Marie, and cerebellar sclerosis.

8. Some tropical diseases have symptoms similar to multiple sclerosis: (*a*) Malaria, (*b*) schistosomiasis.

While the Public Health Service is conducting investigations into the cause and cure of infantile paralysis and into matters of mental health, there is I believe no research under way, either private or public, into these devastating diseases which is in any way commensurate with the magnitude of the problem involved and its public interest.

We respectfully submit that the establishment of a neurological institute under the aegis of the Public Health Service is well worthy of congressional support, and on behalf of the 15,000 members of our society, their relatives and friends, we earnestly urge that the pending bill should receive your approval. I thank you.

Mr. PRIEST. Our next witness will be Dr. Tracy J. Putnam.

Doctor, will you give your full identification for the record at this point, before we proceed?

STATEMENT OF DR. TRACY J. PUTNAM, LOS ANGELES, CALIF., CHAIRMAN OF THE MEDICAL ADVISORY BOARD OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY

Dr. PUTNAM. Yes, Mr. Chairman.

I am chairman of the medical advisory board of the National Multiple Sclerosis Society. I was formerly professor of neurology at Harvard University and still am professor of neurology and neurological surgery at Columbia.

Mr. PRIEST. Thank you, sir.

Dr. PUTNAM. Mr. Chairman and gentlemen, I have a prepared statement, but it is rather long and dull, so with your permission I will try to emphasize some of the important points as they seem to me.

You have heard the stories of some patients with multiple sclerosis and these are typical. I have in my records hundreds of them.

The national society has on its records many thousands of such stories, as you have heard this morning.

This is a heart-rending disease, as everyone who has come in contact with it can assure you.

Now, I should like to present briefly the outlook for the results of scientific research in this field. This group of diseases came to be known in the middle of the last century, and they were simply known by their symptoms and post mortem appearance until about 20 years ago. At that time, we began to learn a little more about them.

It is fair to say that practically all doctors at that time and many doctors still would say to a patient or the relatives of a patient with multiple sclerosis, "You have a hopeless, progressive, and incurable disease. The cause is not known; no one has tried to find out anything about this disease. I do not think anyone ever will try and if he does try, I do not think he will ever succeed."

I have heard these words repeated in essence many times. Any device is helpless, if you think so. For my part, I do not feel at all hopeless about multiple sclerosis. It has been my fortune to spend, beginning 20 years ago, the major portion of my time investigating multiple sclerosis for some years, and later, with other diseases, such as epilepsy and cerebral palsy.

I believe multiple sclerosis is a soluble problem, given the time, the brains, the facilities and the money.

The investigations which we began at Harvard 20 years ago were financed by small contributions picked up here and there, and it took almost as much time and effort to raise the money as it did to do the work, but it has been established that this disease has an evolution. It goes through an acute stage, and in many cases this acute stage seems to be in some way allergic in nature. A very similar disease can be produced in animals. The development of these areas are areas of degeneration which are followed by scars which appear to be preceded by the formation of clots in small vessels of the nervous system. This disease has a regional and climatic predilection. It is commoner in damp, cold climates and perhaps industrial areas, and rarer in warmer dry ones.

We have learned something about the management of patients. I do not feel that we have any specific cure for the disease, but still a great deal can be done for individual patients by a careful study of their symptoms and application of certain principles of treatment to these symptoms.

I firmly believe that this country, and the peoples of the world, would benefit substantially by the establishment of a source of funds for the investigation of diseases of the nervous system. Many of these diseases are interrelated in one way or another. What we learn about one is extremely helpful with another. From personal experience in raising funds, I am skeptical of the possibility of raising funds privately in any adequate quantities to pursue the study of these diseases, and I earnestly request in the name of the neurologists of this country, and also of the many tragic cases which I have seen, that this committee will report some bill which will finance investigation into neurology and multiple sclerosis in particular.

Mr. PRIEST. Thank you so much, Doctor. Are there any questions?

Mr. SADOWSKI. Yes, Mr. Chairman.

Have you had any information from the War Department as to how many cases they have discovered in the Army itself?

Dr. PUTNAM. No; as far as I am aware, they have not published any statistics.

I have talked with Dr. Pearce Bailey, who is the consulting neurologist of the Veterans' Administration, and they have so many cases in the Veterans' Administration that they are considering setting up a special hospital for the custodial care of them. They are considering setting this up in a region which I feel is not ideal, but I believe there is a great advantage in segregating them so they could receive a special study.

Mr. Sadowski. Is the incidence of this disease more prevalent in European countries than Asiatic countries?

Dr. Putnam. According to our best statistics, it is. As I am aware, the highest incidence of the world is probably in Scotland or possibly in the Baltic countries. It is certainly to some extent less in more southern and drier countries, and for some reason which we have not yet analyzed, it seems to be extremely rarer in certain Asiatic countries, notably in China, although it does occur in the Chinese in this country.

Mr. Sadowski. Perhaps the diet may have something to do with it?

Dr. Putnam. I believe that that is possible. There may be some combination of climate and diet, although considering the variation in the climate of China, that does not seem a very reasonable explanation by itself.

Mr. Biemiller. Doctor, a moment ago you referred to the possibility, or at least I thought it was implicit in your remarks, of setting up a neurology institute to cover the different divisions of nervous system diseases. Do you think that is a more feasible procedure than setting up separate institutes?

Dr. Putnam. I believe it is feasible and I believe that it should be possible to find some administrative provision which would prevent some relatively unimportant diseases from receiving the majority of the funds, which has happened. I have known that to happen in omnibus provisions of that kind. That is a danger, but I think not insuperable.

Mr. Priest. Are there any other questions?

If not, Doctor, we appreciate very much your statement before the committee, and your prepared statement will be included in full in the record at this point.

Dr. Putnam. Thank you, Mr. Priest.

(The statement is as follows:)

Statement Concerning Multiple Sclerosis by Tracy J. Putnam, M. D., Los Angeles, Calif.

Multiple sclerosis and related diseases (amyotrophic lateral sclerosis, encephalomyelitis, myelitis, etc.) constitute probably the most common diseases of the nervous system today, and are among the most distressing, tragic, and costly of all illnesses. Their precise incidence is unknown, but it appears probably that there are about 250,000 victims of disorders of this type in the United States. These diseases affect chiefly young adults—men who are just embarking on their careers and family responsibilities and girls who are looking forward to marriage or who are bringing up young families. From healthy citizens they are, without warning, paralyzed or blind or lose control of their balance or control of the bladder or bowels, and many become hopeless invalids, dependent upon their families or on charity, sometimes for 20 years or more. But this agonizing, frustrating, costly group of diseases has received scant attention from doctors and medical investigators, chiefly because of the great difficulty of obtaining funds for investigative work.

These diseases are seldom fatal at once, so that they do not appear prominently in mortality statistics; their victims usually die of pneumonia or kidney disease rather than of the original illness. They are not considered part of internal medicine, to which the major portion of funds for medical research is dedicated; nor have any funds dedicated to mental hygiene been expended upon multiple sclerosis, as far as I am aware. Since I have had many heart-rending experiences with victims of these diseases, and since I have struggled for many years to learn something about multiple sclerosis, and to raise funds and establish facilities to enable other investigators to work on the subject, I have felt it my duty to make trips across the continent in order to attend this and the Senate hearing on the same subject, and numerous meetings of the Multiple Sclerosis Society and various neurological associations, in the hope that a concerted effort may lead to progress toward the relief of a great host of helpless and miserable human beings.

Perhaps my best contribution to this morning's discussion will be a brief sketch of the development of our present knowledge of multiple sclerosis. This disease was first recognized almost simultaneously by an English and a French pathologist about 1837. They both described cases seen at the autopsy table in which there were patches of atrophy and scarring scattered throughout the spinal cord and brain. The French pathologist, Cruveilhier, gave the condition the name of "sclerosis (or hardening) in disseminated plagues," which is now usually abbreviated to disseminated or multiple sclerosis. The condition was, however, considered to be an unimportant curiosity until 1868, when the brilliant French neurologist, Charcot, described a group of symptoms which permitted the recognition of some cases during life. Later he pointed out the great variety of forms of the disease and recognized that it was by no means rare. He also described the related condition, amyotrophic lateral sclerosis, which is often called Charcot's disease.

Charcot not only recognized the symptoms of multiple and lateral sclerosis; he also described the microscopic changes in the issues. As you doubtless know, the central nervous system is composed of myriads of tiny nerve fibers. These have been aptly compared to the wires of a telephone cable, but the human nervous system is infinitely more complex than all the telephone systems in the world.

You might imagine that if a great telephone cable is damaged, for example, by crushing, it is easy to suppose that the softer insulation would be most damaged, but that some—few or many—of the wires might be broken also. This is a reasonable analogy to what happens in the areas of degeneration in multiple sclerosis. We find that the myelin sheath, which has many similarities with the insulation of a wire, is damaged and that many of the nerve fibers which are comparable to the wires themselves may be destroyed. In these foci, or plaques, a process of scarring results and the tissues become hard or sclerotic. So we might say that the disease consists of multiple scars or areas of sclerosis scattered through the nervous system.

All of this was well described in 1868 and surprisingly little information was added to our knowledge of the disease until within the last 20 years. Up to that time, no concerted, sustained, systematic effort had been made to analyze the processes leading to the scars of multiple sclerosis, or to consider what might be done to prevent them or mitigate their effect.

In 1929 a small group of people interested in multiple sclerosis raised a little fund which was to be administered by the department of neurology which was being reorganized at the Harvard Medical, which soon became the most active and progressive center of neurological investigation in the country. I had the honor of being put in charge of the investigation of multiple sclerosis, and later became the professor of neurology there in charge of the department. The work there in the 1930's established several important points, which have laid a firm foundation for modern investigation. First, it was demonstrated that a disease closely resembling encephalitis in its early stages, and multiple sclerosis in its later stages, might follow the production of certain allergic states in animals.

Second, it was shown that the foci of degeneration or scars of multiple sclerosis are usually preceded by the formation of clots in the microscopic blood vessels of the nervous system, and a similar disease process may be produced in animals by blocking the small veins of the nervous system. Third, an analysis of the reported incidence of multiple sclerosis in various parts of the world strongly suggested that it is a disease of cold, damp climates and is relatively rare and benign in warm, dry regions. Fourth, it was demonstrated that, contrary to the prevailing view, systematic reeducation and exercise of the weakened muscles is helpful, and can lead to a considerable rehabilitation in many cases of multiple sclerosis and allied disorders.

In addition to these discoveries, all made before 1940, my associates and I were able to show that the use of an anticogulant agent, dicoumarol, seemed to prevent acute relapses in certain cases. It has no effect on established symptoms, but does seem to have definite protective value. This work was done while I was in charge of the Neurological Institute of New York. While there has been much skepticism on the part of more conservative neurologists in regard to these various doctrines, they received substantial support from independent investigators at a symposium on this subject held in December 1945.

All of the work to which I refer, and indeed most of the scientific work which has been done on the subject of multiple sclerosis since its discovery, has been carried on almost as a hobby or avocation of the principal investigators, or on pitifully scanty funds which have been begged, practically hat in hand, from interested parties. I have personally raised considerable, though always inadequate, sums of money for the study of multiple sclerosis and allied disorders, and I can assure you that it is a most humiliating, frustrating and time-consuming occupation for a scientist. The establishment of the National Multiple Sclerosis Society, and similar organizations for the benefit of sufferers from other neurologic diseases, has been a great step forward, but it is not enough. Research into these dreadful diseases should be expanded on a wider scale. There are still doctors who tell their patients with multiple sclerosis, and with epilepsy too, "You are the victim of a crippling, incurable disease. There is no effective treatment for it. and probably never will be. No one is making any attempt to find out more about it, and I see no prospect of any progress."

The advances in our understanding of diseases of the nervous system during the past 20 years show clearly what can be done if funds and facilities are made available. One form of spinal sclerosis—namely subacute combined sclerosis—has been brought under control, and very substantial progress has been made in the fields of epilepsy and cerebral palsy. The outlook for this group of diseases is certainly hopeless if we all think so, but revolutionary methods of effective treatment have been found for many diseases considered hopeless within our memory.

Mr. Priest. Is Dr. Houston Merritt here?

Will you come forward, please?

Please give your identification for the record.

STATEMENT OF DR. H. HOUSTON MERRITT, NEW YORK NEUROLOGICAL INSTITUTE, NEW YORK, N. Y.

Dr. Merritt. Mr. Chairman and gentlemen, I am a member of the medical advisory board of the National Multiple Sclerosis Society, professor and chairman of the department of neurology of Columbia University; director of the medical service of the Neurological Institute of the Presbyterian Hospital in New York.

The committee has heard a great deal about the subject of multiple sclerosis, so I will make my remarks brief.

You have heard that it is a disease that hits young people in the prime of life, and you have heard that it is a progressive disease.

The average duration of life after the onset of symptoms is 15 years. In the majority of cases, the last 5 years of this is spent as a completely bedridden patient.

The symptoms of the disease are so variable that the condition can imitate practically any other disease of the nervous system. This makes diagnosis difficult.

You have heard that the disease is not diagnosed. In many cases, this is not true. The doctor has made the diagnosis, but he has not told the patient, simply because he knows that in telling the patient, the patient will lose all hope. So as long as possible, he withholds from the patient the diagnosis, and tells only the interested members of the family, and these in turn try to keep the information from the patient.

You have heard about the hopeless aspect of the disease. I would like to turn to a little different view.

This disease is not hopeless, because, when it hits a person, the person may recover. It is not like some of the others, such as cerebral palsy and poliomyelitis that destroys irrevocably. The lesions of multiple sclerosis can heal to a certain extent and the patient can recover. In some cases there have been a remission of symptoms for as long as 20 years. It is not at all unusual for the first attack of the disease to remit and the patient have freedom of symptoms for 1, 2, 5, or 10 years.

Why do I emphasize this? I emphasize this because it shows that nature can do something about the disease and that if we can find the cause and a treatment, even though the patient has once been afflicted, we may prevent further ravages in that patient. It is not hopeless because the lesions can heal themselves, and if we can find the cause, we can prevent subsequent lesions.

If a man suffers only one attack, it is possible for him to be rehabilitated almost completely if we prevent further attacks.

Why is something not done about the disease? We do not know, because so far we do not know the treatment. The medical schools, the research institutes of this country have men who can be put to work on this disease if sufficient funds are allotted.

Research in multiple sclerosis, as has been emphasized by Mr. Owen and other members who have testified here, will be of benefit to people with other diseases of the nervous system if we can find out what causes multiple sclerosis, how the disease cells are affected by some unknown process, we may thereby find out something about some of the other devastating diseases of the nervous system.

Basic research in physiology and pathology of the nervous system this is applied to multiple sclerosis will be applicable to other diseases.

I wish to petition the committee to pass on one of these bills, either for aid for multiple sclerosis or for neurology in general, because I feel that anything that advances knowledge of the nervous system in general will not only help patients with multiple sclerosis, but patients with all diseases of the nervous system.

Thank you.

Mr. PRIEST. Doctor, I appreciate very much that tone of hopefulness that came into your statement.

Are there any other questions?

It is just about time for this committee to recess. Doctor, we thank you so much for your statement.

Dr. MERRITT. Thank you, Mr. Chairman.

Mr. PRIEST. The committee will stand in recess until 12:15, at which time we will reconvene and hope to complete our schedule of witnesses for the day.

(Whereupon, at 11:40 a. m. the committee was recessed to reconvene at 12:15 p. m. this day.)

(At 12:15 p. m. the committee reconvened.)

Mr. PRIEST. We are happy at this time to have our colleague from the House, Mr. Talle. We will be very happy to hear your statement at this time.

STATEMENT OF HON. HENRY O. TALLE, A REPRESENTATIVE IN THE UNITED STATES CONGRESS FROM THE STATE OF IOWA

Mr. TALLE. Mr. Chairman, I appreciate this opportunity to appear before your distinguished committee in support of my bill, H. R. 5073, and similar pending measures which propose to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis and related neurological diseases.

Multiple sclerosis is no respecter of persons. It attacks men and women, young and old, the strong and the weak. Its victims, numbering more than a quarter of a million in the United States alone—can look forward only to crippling paralysis followed by lingering, painful death.

Medical science has made wonderful strides in our times, but without adequate funds there can be no effective research carried on to combat this dread disease.

The legislation under consideration would amend the Public Health Service Act to authorize such research.

Mr. Chairman, prompt and favorable action on this legislation by your committee and by the Congress will bring new hope to present victims of multiple sclerosis, and will contribute to the heatlh and welfare of future generations.

Thank you, Mr. Chairman, and members of the committee.

Mr. PRIEST. Are there any questions? We are aware that you have a crowded schedule, just as most of us do, Mr. Talle, and we will excuse you without questions, and thank you for your interest.

Mr. TALLE. Thank you very much.

Mr. PRIEST. Is Mr. Murphy here?

Mr. Murphy, will you come forward, please?

STATEMENT OF HARRY A. MURPHY, EXECUTIVE DIRECTOR OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY, NEW YORK, N. Y.

Mr. MURPHY. Mr. Chairman and gentlemen, I am the executive director of the National Multiple Sclerosis Society. I have prepared a statement which is before your committee. Much of my statement is corroborative of what has been said before, and it is available to you, and I do not intend to unnecessarily take up any of your time.

However, there is one point in the statement that I would like to emphasize.

I have been engaged in the voluntary health movement for several years now, and since my association with the National Multiple Sclerosis Society—having been with the American Cancer Society for many years—I have come to the conclusion entirely unscientifically, but from a humanitarian standpoint, that this disease in its implications is far greater and far more important than even I believed, when I became associated with this group.

Besides the pain and suffering which has been described to you and which you know so well, the ramifications of multiple sclerosis, the economic and sociological and other phases, are much wider than even cancer, with which I have become familiar during the years.

Since my association with the society, as I have engaged in other work on a national basis for a long time, I have received telephone calls from people whom I have never met, in my own home, for example, as late as 11 o'clock at night asking for help.

These people, these victims and their families and friends, have done a great deal to help themselves. The National Multiple Sclerosis Society owes its existence to those people. In a small way they have done something. In the short space of less than 3 years they have enlisted 15,000 members.

The society in that time has conducted surveys, has established two clinics, and has one, as you have heard, about ready to come into existence.

The society has planned a modest but basically important program of nine projects. In a small way something has been done.

Now these things that have been done hold out some hope for the victims of multiple sclerosis. Upon until 1946 the multiple sclerotic and his family had nothing to look forward to but long painful years of suffering from which only death brought surcease. Today that situation has been ameliorated somewhat, but in actual fact we believe that we have done, the society has done, much more for the member's morale than we have done for the physical condition.

We believe that additional funds for research will maintain that morale, and what is more important, will restore, we hope, some of the hundreds of thousands who are suffering from the disease to an active and useful life.

In that statement, which I submitted to your committee, you will find some figures which we have been able to get.

Since 1947, according to our figures, a total of $241,512.23 has been made available for research in multiple sclerosis. That is in a 2-year period.

Of that amount the United States Public Health Service made a grant of $12,654 to finance a specific project at Cornell University. The National Multiple Sclerosis Society has allocated $194,358 for research out of its very meager funds, and one other foundation in Detroit has allocated $34,500. That sum, small as it is, $241,000 plus, is all that has been allocated and devoted to medical research and multiple sclerosis and it is obvious, I am sure, that in face of the needs the amount is totally inadequate.

We earnestly request that your committee give full consideration, as we know it will, to this problem of getting more money for research in this disease of which we have heard so much and know so much.

Mr. Priest. Mr. Murphy, even with that very small amount allocated for research, the use of that indicates to you that there is great hope in research in this field, if adequately financed?

Mr. Murphy. A great deal, sir. I might say this, too, out of my experience in work in the cancer field, I am sure that if this committee deems it proper, and the Congress, to allot funds for our research in multiple sclerosis, it is going to bring not only hope to the victims but it is going to bring in funds for other phases of the program which are so important. I am talking about education and service and things of that nature. We have found that to be almost the rule.

Mr. Priest. Thank you, sir. Are there any other questions?

Mr. O'Hara. Mr. Chairman, I have one question.

Mr. Murphy, with reference to the sum that you testified to that has been collected in the period of time that you testified to, what amount has been actually used in research?

Mr. Murphy. The figure I gave of the society's $194,000 has been allocated, and is being used in specific research at this point. It is appropriated and allocated at this time. It has not been used, of course, because, as research develops we make payments along a certain basis.

Mr. PRIEST. Are there any other questions? If not, thank you so much, Mr. Murphy, and your statement will appear in the record in full at this point.

(The statement is as follows:)

TESTIMONY OF HARRY A. MURPHY

I am deeply gratified at being afforded the opportunity to speak in favor of the passage of legislation to provide for research and investigation with respect to the cause, prevention, and treatment of multiple sclerosis.

It is always an honor for a private citizen to be called into the councils of government. You will appreciate the sense of responsibility that I feel in this instance when I tell you that to hundreds of thousands of my fellow citizens the piece of legislation which is under consideration here today is the most important which has ben introduced in many years.

The victims of multiple sclerosis, and their families and friends, need and deserve your assistance. They have striven admirably to help themselves by forming the National Multiple Sclerosis Society which has enlisted 15,000 members in less than 3 years. The society has already conducted surveys, established three clinics for the diagnosis and treatment of patients and the training of additional physicians, and has planned a modest but basically important program of nine research projects, which are already underway.

These accomplishments hold out some hope for the victims of multiple sclerosis. The importance to these people of such an elusive and intangible thing as hope must not be minimized. Until 1946, a person stricken by multiple sclerosis had nothing to anticipate except long and painful years of ever-increasing incapacity and suffering, from which only ultimate death would bring surcease. Beyond the immediate circle of his family and friends lay an iron curtain of medical lack of knowledge and public unawareness. Few people knew of this disease; few people cared.

Today that situation has been ameliorated somewhat. But in actual fact, we have done much more for our members' morale than we have done for their physical condition.

Additional funds for additional research will maintain that morale, and what is more to the point, may hasten appreciably the return to health and to a useful life some of the 250,000 Americans suffering from multiple sclerosis.

In setting the number of multiple sclerosis sufferers in the United States at approximately 250,000, I am offering a statistic admittedly based on deduction because a full census is not now possible.

I am aware that this committee is primarily interested in facts. I am also aware, painfully so, how few are the statistical and pathological facts which we can offer to support our contention that the Congress of the United States should pass legislation to combat multiple sclerosis.

A fact may be defined as that which is known beyond reasonable doubt. I can make only one statement about multiple sclerosis which fits that definition.

It is a fact that medical science, at present, unfortunately knows very little about multiple sclerosis.

Multiple sclerosis is one of a group of neurological disorders known as demyelinating diseases, so-called because they attack the myelin, or protective sheath which covers the nerves. According to my nonmedical appreciation, myelin may be likened to the insulating material on electric wiring, and the demyelinating process and resulting paralysis may be likened to the electrical short circuit that occurs when insulation is worn away from wiring, influencing given areas.

What causes the demyelinating process is not known. Once it has started, it cannot be arrested nor can the affected nerves be restored. Its end result may be and most often is total paralysis.

From the imperfect statistics available, it is strongly indicated that multiple sclerosis has its greatest incidence among our young adult population. The disease attacks its victims at the most socially useful and productive period of their lives, between the ages of 20 and 45.

One of the first tasks which the National Multiple Sclerosis Society set itself was the gathering of necessary information relative to the incidence of the disease. Understandably, information of this sort is of primary importance in furnishing leads for medical research.

The results of these statistical surveys have not been to any degree conclusive. Aside from the difficulty of getting busy doctors to report known, properly diagnosed cases to the society, there is another obstacle in the way of accurate statistics. In general, medical practitioners are not well versed on multiple sclerosis, and the disease, according to recent medical suspicion may well be improperly diagnosed in countless numbers of so-called mysterious disorders.

Despite these difficulties, returns from some areas have been high enough to furnish some indication of the national incidence. In one county in Connecticut, for example, 56 cases were reported out of a population of 30,000. For reasons already given, this figure is itself a minimization. However, if we accept the Connecticut figure as an index and apply the rate to the United States as a whole, we arrive at a figure of 224,000 cases in this country.

This figure applies only to multiple sclerosis, which we think is the most widespread of the demyelinating diseases. On the other ailments in this category, such as amyotrophic lateral sclerosis which killed the great, beloved Lou Gehrig, there is no information at all.

It should be emphasized that for purposes of basic medical research, the demyelinating diseases can be regarded as a unit. Progress on one will be progress on them all.

Since 1947, a total of $241,512.23 has been made available for research in multiple sclerosis. Of that amount, the United States Public Health Service made a grant of $12,654 to finance a specific project at Cornell University. The National Multiple Sclerosis Society has allocated $194,358 for research, and one other foundation has allocated $34,500.

Gentlemen, this sum, small as it is, is the largest that has ever been devoted to medical research on multiple sclerosis. And in face of the need, it is totally inadequate.

Hospital beds must be endowed for multiple-sclerosis patients. Doctors and research workers must be trained to do specialized work in the field. The medical profession, in general, must be enlisted in intensified missionary work so that diagnosis will be swifter and surer. Clinics for the treatment and observation of patients must be established in key communities throughout the Nation. The tremendous task of research alone, properly done, is beyond the potential of the Federal Government's present allocation for multiple sclerosis.

This committee must decide whether or not the insidious crippler, multiple sclerosis, should be permitted to continue unchecked in our Nation. On that decision rests the hopes of hundreds of thousands stricken today, and the future health of unborn generations.

Mr. PRIEST. Our next witness will be Miss Lawry.

STATEMENT OF MISS SYLVIA LAWRY, EXECUTIVE SECRETARY OF THE NATIONAL MULTIPLE SCLEROSIS SOCIETY, NEW YORK, N. Y.

Miss LAWRY. Mr. Chairman and gentlemen, I am executive secretary and founder of the National Multiple Sclerosis Society.

Gentlemen, I want to tell you how the organized attack against multiple sclerosis began. I am told it is a monument to what is possible within the framework of our democratic country.

The first awareness I ever had of multiple sclerosis was when, one morning, my younger brother, at the age of 20, awoke to see in front of him two tassels instead of one, suspended from his bedroom-window shade.

Up to that moment he had been in perfect health and an outstanding athlete at school. This strange phenomenon—double vision—was the forerunner of even stranger symptoms. Soon a "pins and needles" sensation developed in various parts of the body and led to his inability to walk and maintain his balance. Any sustained activity caused such weakness that it became necessary to lie in bed most of his waking hours.

He turned to the medical profession to find out what the trouble was, and he was told it was multiple sclerosis. He happened to be told this by a doctor who said that there are only two other reported cases in medical literature with this strange ailment. You know, from what you have heard up to now, how false, how preposterous, that statement was, but it reflected the general ignorance on the subject.

My brother then turned to the medical books—and then to plans of suicide.

In desperation, I placed a public notice in the New York Times which stated: "Anyone recovered from multiple sclerosis please communicate with patient." To our great amazement answers flocked from not only this country, but from a number of foreign countries. Hundreds of replies came as a result of that notice, from people who were seeking the hope that I was seeking, and wanted to be informed should I have uncovered a clue.

A flame was ignited, gentlemen, which gave to the patient and the member of the family involved with the disease their only hope, a chance to band together and institute an organized attack upon this disease.

A handful of patients and relatives then called a meeting, and at that initial meeting $250 was placed in the Treasury and our organization was created.

They appealed to a leading authority in this field, Dr. Tracy J. Putnam, then director of the New York Neurological Institute, and he organized a medical advisory board. They then sought outstanding lay leadership and learned that multiple sclerosis strikes in high places as well as low.

An outstanding board of directors evolved. That amount of $250 has since spiraled to $400,000 and a membership of over 15,000 through such devices:

A Buffalo, N. Y., teacher in a wheel chair was honored at a dance given by his students; the proceeds were sent to us.

A patient organized a block party in Brooklyn.

A Florida patient auctioned all her antiques at home as a contribution.

A new home of an Ohio patient was put on public display, and admission charges were sent to us.

A young war veteran afflicted with multiple sclerosis sent in his Government pension check.

A bedridden patient in New Jersey hand-painted Christmas cards and donated the proceeds.

A beautiful young girl in Virginia propelled herself in her wheel chair through the streets and stores of her town and pleaded for contributions; and, finally, this is an excerpt of a letter about Ted Mucci, of Pennsylvania, one of our earliest and stanchest supporters, the patient who enlisted the sympathy of his friend, Congressman James G. Fulton:

Last Good Friday, Ted had a bad spell, but God did not take him then. On the following Tuesday I was there as usual, and he said to me: "I was awful sick on Friday, but I guess God is giving me time to beat this thing. If time runs short, and I don't make it, I want it known that people are to give money for the association instead of flowers."

Ted has had his wish; we received our money.

Gentlemen, our patients are weary and weak—they now appeal to the strong and to their Government to help them in their battle.

Mr. PRIEST. Miss Lawry, the committee appreciates your very moving statement and your appearance before the committee today.

Are there any questions?

If not, thank you very much.

The Chair is in receipt of a prepared statement by Dr. Rene Cailliet, M. D., medical supervisor of the Kabat-Kaiser Institute of Washington, D. C., in support of the legislation. Without objection, it will be included at this point in the record, and copies are being handed to the committee.

(The statement is as follows:)

STATEMENT PRESENTED BY RENE CAILLIET, M. D., MEDICAL SUPERVISOR, KABAT-KAISER INSTITUTE, WASHINGTON, D. C., REGARDING MULTIPLE SCLEROSIS BILL, H. R. 62

It is for the purpose of strongly urging passage of H. R. 62 by the House of Representatives that this statement is willingly offered. The provisions and proposed action stated in said bill, and its adequate enactment, will fill a definite need in the advancement of studies aimed at the prevention and cure of multiple sclerosis. Such studies are at present being inadequately undertaken by existing research, and the situation socially and economically, as well as medically, is demanding more intensive studies.

Multiple sclerosis is a disease of unknown cause, and consequently has no known treatment that can be considered curative or prophylactic. The prevalence of this illness is considered to be close to that of infantile paralysis, and is further sinister in that it most commonly affects persons in the teens, twenties, and thirties. It cannot be considered a disease with serious mortality in this age group, but causes severe disability when the patient is in his greatest productive, as well as his most enjoyable years.

Very little coordination at present exists in the theories and researches held for multiple sclerosis. The numerous theories and even more numerous treatments advocated only give further evidence to the ignorance of the disease. The pathology resulting from the disease itself has been studied thoroughly, but has not yielded clues as to the basic factors. Until recently no such damage has been caused nor could be observed in study animals. In the midst of this confusion stands the patient—with good general health, a definite disability and more impending disability—constantly seeking help, and in the main being neglected in spite of the earnest desires of the physician. His wanderings take him to the ends of the trails possible with his financial means; no specific cure can be offered, his disability is denied rehabilitation, and even vocational rehabilitation is denied him. His case files are closed because his disease is unknown, misunderstood, not treatable, and considered progressive or recurrent.

Research in multiple sclerosis, as advocated in H. R. 62, will centralize scientific thinking and vastly supplement the present research. It will bring multiple minds from multiple fields to study the disease in all its aspects. It will make funds available for this study not at present available. It will foster treatment centers of over-all thought, rather than limited thought along one line. It will study a disease that is rapidly assuming serious social and economical proportions.

Much can be done for these patients and many more studies must be undertaken so that more will eventually be done. Passage of H. R. 62, its enactment and efficient fulfillment is a definite need.

Mr. PRIEST. Also, a further statement from Henry J. Kaiser, Jr., who is at the present time chairman of the California chapter of the National Multiple Sclerosis Society.

This statement will be included in the record at this point.

(The statement is as follows:)

STATEMENT OF HENRY J. KAISER, JR., ON PUBLIC HEALTH, SCIENCE, AND COMMERCE AT A HEARING ON 13 MULTIPLE SCLEROSIS BILLS AND TITLE II OF THE NATIONAL HEALTH BILL

GENTLEMEN: I have had a personal concern with the disease, multiple sclerosis, and its effects since, in my college days at Stanford University, I acquired its first tentative symptoms. These were purely sensory; a numbness of the hands and feet which disappeared after a short period. I went about my business without thinking too much about the matter, even though the symptoms recurred from time to time. Then during the war, in 1945, the business of making shells and more shells in our Denver plant became of special urgency. The Battle of the Bulge underscored its importance, and there could be no let up. Round the clock work was the order of the day. During a period of 3 months, I lost 60 pounds, and, one day when I was walking down the hall, my legs collapsed under me. No warning at all—they just turned to rubber.

The doctors told me I had multiple sclerosis, and proceeded to sap my hope and whatever courage I had by telling me the disease was incurable. In effect they said to go to bed, rest, and waste away to a prolonged living death.

To a man who was born into a family whose philosophy is action, this was a recommendation of despair. It was not the fault of the doctors. It was that they knew nothing about the disease—far less a cure.

I was fortunate to have the financial means by which I could seek relief. The great majority of sufferers in the United States have not.

After seeing a series of the Nation's top neurologists, who felt sorry for me but could do nothing, I began to feel sorry for myself. And this is the beginning of the end in the case of multiple sclerosis as in everything else. About this time, and none too soon, I heard about a man who was doing amazing things with spastics, and paraplegics. He was Dr. Herman Kabat. The first ray of hope began to glimmer when he talked to me. Yes, something could be done, if I was willing to work, he said. I can assure you gentlemen, that my answer was a positive "yes." A rigorous regimen of physical-therapy began which I keep up to this day. Hope and courage rose with every muscle that came back into coordination with the nerves. A wiggling toe became a major triumph—the cherished goal of a return to active normal life became increasingly attainable. I have reached that goal—able to work along with others in doing my share of the jobs that have to be done. That is all these multiple sclerosis sufferers ask—that they be given a chance to take their place in society as independent, self-respecting citizens. Having found the way back to active normal life. I was determined I would use those regained energies toward helping other less fortunate victims to find the same road back.

I have found, however, that what I could do, and what the other valiant pioneers could do, is woefully inadequate to meet the problem. Something can be done as it was done in my case to rehabilitate the victims. But the treatments are costly, and only a comparative few can afford the long, tedious and expensive treatments. They are doomed to a living death in wheel chairs or bed, an insupportable burden on their families, and an intolerable tax on the charities of local communities.

No one who has seen the terrible destruction of human bodies of hope and happiness that this disease visits upon its victims and their families can be so inhuman as not to be urged to do something about it. In southern California, where I am chairman of the California chapter of the National Multiple Sclerosis Society, we have 1,118 members, a good proportion of whom are victims. This is indicative of the widespread havoc the disease has wrought. Doctor Tracy Putman, the noted neurologist and chairman of our medical board, tells me that the victims of the disease number twice those of active polio. And we have another clue to its tragic prevalence. Some time ago, a casual appeal was made on a commentator's broadcast whose Hooper rating was about three. Over 7,000 people responded to his request—either victims of multiple sclerosis or persons who knew of sufferers.

Such responses are black with the tragedy of lives blighted in their prime. They are cries of anguish for something to be done.

And there are others whose pathetic cases place a special urgency on this social problem which this committee can help greatly to resolve. I can name them off by the scores; a minister, a former concert pianist, and an ex-football star. They have struggled and fought their fights with hope, courage, and determination. They have success within their reach, but poverty stands in front of them—a black shadow that inevitably will enshroud them again in their living death, unless something is done. Can the America whose ingenuity and humanity shines throughout the world continue to allow itself the inhuman luxury of indifference to this appalling condition.

I am sure that this committee will join with the mounting numbers of good hearted people in the Nation who are marshalling their dollars and their talents to do something about it.

There is the National Multiple Sclerosis Society whose members for years, have given unstintingly of their time and money. Under the direction of their medical board, chairmaned by Dr. Tracy Putnam, the money has been well spent. They have set up nine basic research projects, seeking relief for the victims and curative techniques. These are vital and worth while projects, but merely a bare beginning. There is the new organization of newspaper people and baseball figures who have pledged support of the cause through the recently established Lou Gehrig Memorial Fund. In the West, we have gained heart-warming support from editors and owners of baseball teams and others in this project; and the civic, political and religious leaders who form the California chapter's board of sponsors, of the National Society continue to concentrate their energies on the problem.

As I see it, there are four basic objectives in the fight against the disease, which are as follows:

1. Research—for without intensive field investigation, we can never hope to determine the cause of the disease or its cure.

2. Rehabilitation. Financial support must be given those thousands now afflicted in order that rehabilitation treatments may be made available to them. In addition, a continuing study of the various rehabilitation techniques should be inaugurated.

3. There is a vast amount of statistical information that is yet to be developed on multiple sclerosis. As you know too well, little or nothing is known about its incidence, its prevalence, or its geographic importance, and although the National Multiple Sclerosis Society is attempting to make a Nation-wide survey along this line, it will be years before it will be completed because of the modest funds with which they have to work. I am sure that this phase could be greatly accelerated under a national bill, such as you have introduced.

4. There is also a decided need for much educational work in multiple sclerosis, not only with the laymen, but also with the medical profession in order that they may better serve the people who are so desperate at this time.

I think that I am expressing the fervent hopes of all the sufferers and their friends in the Nation in asking you to act favorably on a multiple sclerosis bill in the House of Representatives so that a beginning can be made toward reaching these objectives.

Mr. PRIEST. Without objection, statements that have previously been made before the Senate Committee by Senator Charles W. Tobey, Mrs. Lou Gehrig, Mr. Daniel R. McIver, and Mr. Ralph I. Straus, president of the National Multiple Sclerosis Society, will be included in the record at this point.

(The statements reprinted from the Senate hearings are as follows:)

STATEMENT OF HON. CHARLES W. TOBEY, UNITED STATES SENATOR FROM THE STATE OF NEW HAMPSHIRE

Senator TOBEY. Now, Mr. Chairman, and I add for the sake of the record and members of the committee, multiple sclerosis meant nothing to me until some years ago when a member of my family was diagnosed as having that disease. Since then we have learned plenty.

Two years ago, on January 2, I was sitting in my office when a man came to see me with one of his lawyers. My secretary, Mrs. Ramsdell, said, "I think it's Henry Kaiser." I went out and found it was Mr. Kaiser. He has his secretary with him, or one of his attorneys, and he came into my office about a matter which pertained to his business, some legislation he was seeking. As he sat in my room he looked on the mantlepiece and like most Senators they have the pictures of those that they love around their room. He looked up and said, "Is that your family?" and I said, "Yes." He said, "Are they all well?" And I said, "All but my daughter who has an incurable disease, and it is either wheel chair or death."

He said, "What disease is it?" And I said. "It is multiple sclerosis." He jumped to his feet; "I challenge you," he said, "for making that statement. What authority have you for saying it?" "Well, I have the authority of medical experts who tell us that, and many of them, not one, but many."

"Well," he said, "my son had it 4 or 5 years ago and he couldn't walk, he crawled on his hands and knees." He said he began certain treatments of physical therapy and he said that the treatment is really remarkable. "My wife and I have founded an institute to try and help the thing." He being a California man and my daughter and I just being back from California, my heart sank. So I said, "Where is the institute, in what part of California?" He said, "In Washington." Then my heart leaped. He turned to his secretary and said, "Make an appointment for Senator Tobey to take his daughter there tomorrow morning at 9 o'clock," which I did.

She has been up to this institute and has been taking very regular earnest treatment for 2 years more or less now.

What I am getting at is this: This institute is doing a noble work, but it has nothing to do with finding the cause and cure for multiple sclerosis. The genesis of this meeting today is to enlist the feeling, the hearts, and the minds of the Senate committee before us here today and the Senate itself, and the Appropriations Committee, to put into effect some appropriations to bring about a research agency under the National Health authorities here to try and find the cause of this hellish disease—and the word, "hellish" is mild compared to what I might use.

I am delighted to see my friend from Missouri, Senator Donnell, at this table. Thank you for coming.

Senator DONNELL. Thank you, Senator.

Senator TOBEY. This meeting is in the interest of trying to aid the sufferers of this terrible disease, multiple sclerosis.

It is one of the most obscure diseases known to science. They have found no cure up to the present time. There has been very little work done in research. The average patient is told, "You can rest. There is not much we can do for you." The heart sinks, but they fight on.

Now comes the challange to the Senate of the United States, and it is a challenge. We cannot let this thing go any longer. There are a quarter of a million people suffering from the ravages of this disease today, and it is progressive. God knows what it can do tomorrow morning to any patient in this room.

But there is a most wonderful spirit of zeal and interest on the part of these men and women afflicted here to help their fellowmen. God put something into the souls of men and women stricken with this thing—love for their fellow men. They want to get well, and they want others to get well, so they are in earnest down here this morning. Look at them.

So I, as a father of a sufferer, introduce this legislation. There isn't a medical man in this room, and I will include the Senator, who would not lay down his life at this moment if he could find a cure for this thing. But we are challenged. We cannot take this thing lying down. There is money enough in this country to take care of this job. When we spend $5,000,000,000 for the Marshall plan—which I voted for—and when we spent $12,000,000,000 every 30 days in the Wold War to kill men and destroy capital property forever, we cannot for a moment sit back idly and say, "We cannot appropriate whatever millions are necessary to find the cause, and the research to look into this hellish disease and to give men courage and faith to restore these things." We may not be successful, but God will hold us responsible unless we try to do something for them.

Well, we have a notable company present here today. We have some of the best known medical men in the country: Dr. Traeger, Dr. Putnam, we have Mr. Straus, the head of the Institute of Multiple Sclerosis. We have the staff officers here.

We have here before us men and women who are afflicted, in wheelchairs, and otherwise, whose hearts are burning for help so that they can go back to life.

We are going to do something a little different than the average hearing, Mr. Chairman. We are not going to be more than 2 hours, but we are going to do a little visual education right at the beginning of these hearings. We are going to put on a moving picture, 15 minutes or so of multiple sclerosis, the patients at work, trying to be restored, and let you see, for a fact, how these lives have been damaged. Then you are going to say, "There stand I, but for the grace of God."

I want to introduce at this time a man who has done a great deal in the way of holding this thing in check, through the physical therapy of the Kabat-Kaiser

Institute, Dr. Rene Cailliet, of the institute, and I am glad to shake hands with you, Dr. Cailliet. I owe you a debt of gratitude, sir.

Dr. CAILLIET. Thank you, sir.

Senator TOBEY. Is Dr Kabat here, too?

Dr. CAILLIET. Yes, he is.

Senator TOBEY. Stand up for a minute, sir.

(Dr. Kabat stands.)

Senator TOBEY. You will put these pictures on?

Dr. CAILLIET. Yes, sir.

Senator TOBEY. When he is through we will proceed to put on these other people here, Mrs. Gehrig, Dr. Traeger, Dr. Putnam, and the different members who have have come on from New York and California to testify.

Dr. CAILLIET. Ladies and gentlemen, the purpose of this film will be basically:

1. To introduce to those present here who are not familiar with the disease just what this disease can do from a practical viewpoint. I do not intend to delve into the pros and cons of treatment, or the ideology of the cause of the disease, but more to show how it can affect, what age group it can affect, what status in life it can affect, the social-economic aspects of the disease, and I will, for the most part, let the film depict itself.

We fortunately have many patients here who are living examples and there are two of the pictures shown here whose participants are actually in the audience.

Senator TOBEY. While they are preparing the arrangements for the picture, Senator Humphrey, I would like to introduce you to these people, so they will know who you are. This is Senator Humphrey, of Minnesota. I appreciate your coming very much, Senator.

Senator HUMPHREY. I came for you, sir.

Senator TOBEY. Let us proceed with the film.

(A short interval.)

Senator TOBEY. Mr. Chairman, it is very evident the lighting is not sufficient to see the pictures. We will have to dispense with this and take the oral testimoney at this time, much as I regret it. We are not responsible for the lighting conditions.

Now, Mr. Chairman, before introducing these witnesses, as one having authority I would like to call the committee's attention to the fact that we have as guests here today an interesting group of people. Here they are. Many of them are in wheelchairs, many of them sufferers from this disease. They have come down here to lend their presence and be with us this morning. We welcome them very much, indeed.

We offer the hope and prayer to you stricken people that the money which we hope the Congress will appropriate and to be put into the work of research in this country, will lay grounds not for despair, but for new courage and hope. We will go along with you and do everything we can for you.

Now, Mr. Chairman, I have been reading—and I am an exponent of the Hoover plan for reorganization of the executive branch of our Government—I have read each report that has come out and have spoken over the radio about it, and believe very fully in its purposes.

In the volume on medical activities, page 1278, I quote as follows: The title is "To Provide Better Organization for Medical Research." The Commission brought out the amazing fact that only 4 percent of the 1¼ billions which our Government now spends for medical services—only 4 percent—is spent in research, when medical science stands at the threshold of so many new conquests of disease. Over 85 percent of this total expenditure during the last fiscal year was for direct medical care. The rest went for public health, research activities, training and administration. The expenditures for research were less than 4 percent of the total.

The health of this Nation demands the maximum employment of present scientific knowledge to control disease and of research to find new means for the prevention of disease. Such research must be stimulated and supported to the maximum limits of available manpower. The Nation's future can best be protected by using every means to prevent disease.

Some years ago I went to a gathering in Providence, R. I., of the New England Council. Sitting around that table was a group of economists. One man there, who is one of the leaders in the Nation, said, "Too often we confuse education and research. Let me give you a definition. Education is the problem of diffusing knowledge. Research is the job of extending the borders of knowledge." That is what we are trying to do in this association and through this bill here.

So we seek to get the Congress interested to form a group, a multiple-sclerosis group, in the Department of Health with proper appropriations to aid research to find the cause and cure of this hellish disease.

Without more ado, I am going to now call on Senator O'Mahoney, if he is here. He jointly introduced the bill with me.

I now present to you a most interesting personality. She came down here from New York, and she is the widow of a man whom we all loved, the "Iron Man," Lou Gehrig. Mrs. Gehrig saw that husband of hers, that magnificent specimen of manhood, crumple up with sclerosis, and finally pass away. She has given her life, time, and interest to doing something for mankind in his memory.

I present to this gathering to speak in her own way, Mrs. Lou Gehrig of New York.

STATEMENT OF MRS. LOU GEHRIG

Mrs. GEHRIG. Ladies and gentlemen, I feel deeply the honor of being called to offer my testimony as a citizen on legislation under consideration by the United States Senate.

I am not an expert on anything and I should not have been persuaded to appear here at all if I did not feel that legislation aimed at controlling multiple sclerosis and similar neurological diseases is of the utmost importance to the people of the United States.

It is a tragic fact that my testimony on this subject is almost as acceptable as that of any doctor in the land. This is not an indication of my erudition. It is an indication of how little is known concerning multiple sclerosis—even by the doctors who are most interested in it.

Multiple sclerosis is probably the most common of what the medical profession calls the degenerative diseases. To this group also belongs amyotrophic lateral sclerosis, the disease of which my husband, Lou Gehrig, died. The degenerative diseases have so many features in common that the basic research which must be accomplished before the cause and cure is discovered for them, will be the same for many years to come.

Above all, there is one terrible similarity which multiple sclerosis and amyotrophic lateral sclerosis share. These diseases do not attack the aged and infirm as a general rule. They select as their particular victims, young, vigorous people who normally should have had many years of useful productive life ahead of them.

I saw it happen. My late husband, Lou Gehrig, was a professional athlete. He didn't smoke, he didn't drink. He spent most of his life under training restrictions. His diet was regulated, he got plenty of rest. Needless to say, he was in excellent physical condition.

Then he was stricken by this insidious disease.

At first he simply couldn't play baseball with the skill which later on won him a place in the Cooperstown Hall of Fame. Then he couldn't play well enough to stay in the Yankee line-up. Finally he couldn't play baseball at all.

After his retirement from the game that he loved, he accepted a position as one of New York City's parole commissioners. This was a job very much to his taste, involving as it did the fight against juvenile delinquency. Because of the reverence with which the boys of those years regarded him, and because of his own great enthusiasm for the work, he would have been an enormous asset to the community in that position.

But he was not able to continue even that sedentary work.

As the disease progressed, he couldn't dress himself, he couldn't feed himself, he couldn't walk.

Two years after he hung up his old Yankee uniform for the last time, he died.

Gentlemen, we all "owe God a debt," as Shakespeare puts it. That my husband should pay his debt to God sooner than most men is regrettable, but not uncommon in the degenerative deseases.

But to watch someone close to you become a helpless, hopeless paralytic and to know that medical science is powerless to halt the progress of the disease, is something which no person should be called upon to endure.

The doctors tell me that the best estimates indicate there are more than a quarter of a million people in the United States who are afflicted with multiple sclerosis or a related disease.

Let me emphasize the fact that the families of these unfortunates are also suffering.

A million Americans need the help which only medical research can bring. Some effort must be made to find a cure for these diseases. To carry on this research medical science needs all the assistance that Government can offer.

I understand there is some disagreement as to the best method of applying this Federal aid. Persons better qualified to do so than I must iron out that difficulty. My strongest plea is for a prompt agreement on the legislation needed and then the immediate passage of that legislation.

Thank you for your kindness.

STATEMENT OF DANIEL R. McIVER, WEST WARWICK, R. I.

Mr. McIVER. I am Daniel R. McIver, and live in West Warwick, R. I., where I am president of the Original Bradford Soap Works, Inc.

I am 40 years old and, to the best of my knowledge and belief, was afflicted with multiple sclerosis in February 1942. Not one of the 26 doctors and specialists of neurology whom I have consulted since then has been able to tell me the cause or a cure for this disease.

Before I was afflicted, my normal business activities included a great deal of traveling and active plant supervision. Since then, it has been necessary to relegate more and more of this work to others, until today it is practically impossible for me to pursue any of this type of executive business activity. I used to think nothing of working 14 or more hours a day. Now, 5 hours at a desk is the maximum extent of my physical endurance. At the same time, I used to take active part in many civic, service, fraternal, and social organizations. I have served as chairman of the Red Cross drives, worked with the community chest and various other welfare and fraternal groups. It has become necessary for me to step aside in practically all of this worth-while civic work. It also has been necessary for me to give up any and all participation in any of the active sports which I used to love so well, such as sailing, skiing, fishing, hunting, and so forth. I cannot even go out in the yard at home and stand up to toss a rubber ball back and forth to my 5-year old son.

I further state that, while I have spent some $20,000 consulting and carrying out the suggestions of the above-mentioned 26 doctors, I can see no tangible benefits therefrom.

I urge you, gentlemen, members of the Labor and Public Welfare Committee, to give your favorable consideration to the passage of this Multiple Sclerosis Act as the first step, through research, in finding the cause and a cure for this very prevalent neurological disorder. I urge this, not only for the benefit of myself, but the many other present victims, and in order that our children and grandchildren who will probably be afflicted in the prime of their young adulthood—between the ages of 20 and 40—may be spared not only the expenditure of money, but the loss of their most productive years.

STATEMENT OF RALPH I. STRAUS, PRESIDENT, NATIONAL MULTIPLE SCLEROSIS SOCIETY

Mr. STRAUS. Mr. Chairman, it is with a deep appreciation of the responsibility this occasion has thrust upon me, and with a feeling of great hope that I address this committee.

It seems to me that consideration by a committee of the United States Senate of legislation to combat multiple sclerosis is an important social achievement. It indicates a general acceptance of the fact that disease is everybody's business, and that which is everybody's business is the business of government.

In the 80 years that have elapsed since the eminent French neurologist, Jean Martin Charcot, first identified the disease now known as multiple sclerosis, little, if any important progress has been made in the field concerning its cause and effective treatment.

First considered a rare disease, modern diagnostic technique has established multiple sclerosis as a common neurological disorder. For example, a 10-year study from 1929 to 1939 in the city of Baltimore, Md., disclosed that the disease occurred with a frequency of approximately 18 cases per 100,000. More recent indications disclose that the rate of occurrence is many times greater.

Medical authorities firmly believe that there are presently more than 250,000 multiple sclerosis victims in the United States. Eminent neurologists throughout the Nation express the opinion that, if properly diagnosed, the present number of persons afflicted with multiple sclerosis would probably be substantially increased.

Because so little is known about the disease, only a small fraction of the Nation's physicians are competent to make a positive diagnosis in patients exhibiting the early symptoms.

Unlike cancer, heart disease, polio, and tuberculosis, multiple sclerosis is not well known to the general public. Likewise, pronunciation of its name is difficult. But it remains a heart-rending fact that the disorder has created a serious social problem. Any disease which can strike its victims mainly between the ages of 20 and 45 is a tragedy of which our Nation must take full cognizance.

Multiple sclerosis is a disease of the young adult. It attacks him during the period of life which is normally the most productive socially and economically. It neither respects age, sex, race, nor social position. Multiple sclerosis strikes with equal impact among the wealthy and among the poor. Victims totally incapacitated by the disorder cannot earn their livelihoods. Unable even to help themselves they become a burden to their families and, eventually, dependent upon the community. Fifteen or twenty years of agonizing helplessness is not an uncommon occurrence among multiple-sclerosis victims.

In my particular family my mother has been afflicted with the disease and has had it for 30 years. We are fortunate in being able to provide her with excellent nursing care. For the vast majority of people, however, this is not possible, and you can imagine the tragedy of a home where one person is confined to their bed and the other members of the family have to wait on them hand and foot.

I submit to this committee, and to the people of the United States as well, that multiple sclerosis is a social menace of the first magnitude and must necessarily concern our community as a whole.

Most of its victims become economic parasites. They are no longer productive human beings.

We might as well be candid about it, practically nothing of medical value is presently known about the cause, control, or effective treatment of multiple sclerosis. For all intents and purposes our knowledge concerning the disease is practically the same as it was 80 years ago.

However, many theories have been propounded, some of which have proven to be of no value. Others have indicated sufficient promise to merit their further investigation.

The possibility that multiple sclerosis might be brought about by infection of one sort or another needs thorough investigation at competent hands. Similarly, the recent hypothesis that the disorder may have an allergic basis is presently being studied at the Neurological Institute of New York under financial aid made possible by the National Multiple Sclerosis Society.

Because many victims of the disease exhibited an abnormal clotting mechanism of the blood, that aspect is also being investigated in the hope that it may disclose a new or improved method of treatment. Prior to 1946 no organized effort of any kind had ever existed to aid the victims of multiple sclerosis.

Through the efforts of victims, their friends and families, the National Multiple Sclerosis Society was formed in 1946. In dramatic, but unpublicized fashion, the impetus to attack multiple sclerosis arose from the efforts of those who for generations had vainly sought aid. Under the leadership of outstanding medical and lay persons the National Multiple Sclerosis Society was formed. Today its membership numbers over 15,000, and extends throughout the 48 States of this Union and a sister organization has been formed in the Dominion of Canada. In addition to that, we are corresponding with eminent physicians in almost every civilized country in the world, exchanging information with them.

Through the untiring efforts of patients, friends, and their relatives, the society has undertaken a modest research program—the first organized effort of its kind in our history.

Important as these efforts are, they are inconsequential in the face of what remains yet to be done. An expanded research program aimed at discovering the possible causes, control, and effective treatment of this malady should and must be instituted as quickly as possible. To do that, three things are required: (1) An organized and well thought-out plan of attack; (2) the employment of outstanding researchers and technicians necessary to implement such plan, and (3) the necessary funds to underwrite the entire operation.

The first two items I have just mentioned already exist in part. The National Multiple Sclerosis Society has what it believes to be the beginning of a workable and effective program of basic and clinical research. Throughout the Nation's medical schools and hospitals there are barely a sufficient number of trained persons to start such research effort. What we do not have are the necessary funds to implement the plan.

Within the scope of the United States Public Health Service Act there presently exists a mechanism whereby grants-in-aid may be procured for research purposes properly approved. Unfortunately, the budget of the United States Public Health Service has never been adequate to provide the funds for all approved requests for research grants-in-aid. In fact, even those grants that secured approval of the United States Public Health Service Study Section have not always been able to receive the funds requested.

The Public Health Service Act, section 313, states:

"To secure uniformity in the registration of mortality, morbidity and vital statistics, the Surgeon General shall prepare and distribute suitable and necessary forms for the collection and compilation of such statistics which shall be published as a part of the health reports published by the Surgeon General."

We approached the Public Health Service in an attempt to get them to make a study of the morbidity of multiple sclerosis. Because of the fact they had insufficient funds, our society had to appropriate $25,000 of our own moneys to undertake this particular task.

Senator TOBEY. That was only a drop in the bucket, was it not?

Mr. STRAUS. That was only the beginning.

Senator TOBEY. Infinitesimal, so far as the problem goes?

Mr. STRAUS. Infinitesimal. They were our moneys and not Federal moneys.

I know that the requests for funds before this committee for matters concerning the health of our people are numerous. I also know that there are diseases, for which aid has been requested, whose victims are larger in number and with whose history this committee is more well acquainted. But I submit that none of the diseases with which mankind is afflicted are so steeped in tragedy and so thoroughly neglected as is multiple sclerosis.

A Nation whose Congress can find it in their power to spend billions for foreign relief, must surely find it in their power to aid those who have been denied the right to live a normal adult existence.

A Nation which can invest billions in steel and armor must understand that its first line of defense is a healthy populace.

In the name of hundreds of thousands of known multiple sclerosis patients, in the name of hundreds of thousands of unknown others and in behalf of their countless family members and friends, I strongly urge this committee to make available the funds necessary to undertake an organized assault against the cruel crippler called multiple sclerosis.

Mr. PRIEST. The committee will stand adjourned until 10 o'clock tomorrow morning.

(Whereupon, at 12:25 p. m., the committee was recessed, to reconvene at 10 a. m., Thursday, June 23, 1949.)

NATIONAL HEALTH PLAN

THURSDAY, JUNE 23, 1949

House of Representatives,
Subcommittee on Public Health,
Science and Commerce of the Committee
on Interstate and Foreign Commerce,
Washington, D. C.

The committee met at 10 a. m., Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills)—national health, with respect to title II—medical research.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills)—national health.

H. R. 3934—Omnibus medical research bill.

Cerebral palsy: H. R. 1729, by Mr. Priest; H. R. 3258, by Mr. Biemiller, and H. R. 3645, by Mr. Battle (identical bills)—to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of cerebral palsy, and for other purposes.

Epilepsy: H. R. 3893, by Mr. Biemiller—to amend the Public Health Service Act to provide for research and investigation as to the cause, prevention, treatment, and possible cure of epilepsy.

Leprosy (Hansen's disease): H. R. 4030, by Mr. Peterson—to amend the Public Health Service Act to improve the leprosy situation in the United States, and for other purposes.

Cancer, heart disease, and poliomyelitis: H. R. 3929, by Mr. Hand—to provide for the mobilization of the scientific resources and knowledge of the United States for the purpose of seeking the causes and cure of cancer, heart disease, infantile paralysis, and other diseases of mankind.

Mr. Priest. The committee will come to order.

We have before us this morning a continuation of hearings on medical research. The committee is considering a number of separate bills dealing with this subject. We are considering also title II of the omnibus bill, H. R. 4312 and H. R. 4313, the bill H. R. 4918, and a number of companion and identical bills.

We are considering today also bills dealing with cerebral palsy, epilepsy, and leprosy.

The chairman desires to state at this time that the House meets at 11 o'clock today, and we do not know how soon after the House convenes there may be a quorum call. We have a large number of witnessses. We hope to accommodate all the witnesses in some manner during the day, but if the schedule is somewhat irregular you will understand that after 11 o'clock today the responsibility of the Members is on the floor, and if a committee sits it must be by special permission from the House. We hope that, to the best of your ability, you will cooperate with us on whatever irregularity may develop.

Without objection, we will insert at this point reports from the Federal Security Agency, the Bureau of the Budget, and the Veterans' Administration.

(The reports are as follows:)

FEDERAL SECURITY AGENCY,
Washington, June 14, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your letters of February 15, March 8 and 23, 1949, for reports on H. R. 1729, H. R. 3258, and H. R. 3645, identical bills to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of cerebral palsy, and for other purposes.

These bills would establish a National Cerebral Palsy Institute in the Public Health Service and would authorize the Surgeon General to conduct, promote, and coordinate—directly and through grants-in-aid, fellowships, and traineeships—researches, investigations, public education, demonstrations and control programs relating to the cause and prevention of cerebral palsy and to methods of diagnosis, treatment, and restoration of persons afflicted with this disease. The bills would also establish a National Cerebral Palsy Council to review and make recommendations regarding requests for grants-in-aid for research, education, and control; the bills provide in considerable detail for four subcommittees of this Council to be concerned primarily with obstetrics, treatment, training of professional personnel, and educational research on the cerebral palsied child.

Research on the subject of cerebral palsy and related conditions fits into the program of research in the Public Health Service. The importance of work in this field is recognized and authority exists for its conduct and support by the Surgeon General through the National Institutes of Health. It is expected that investigations on this subject will be conducted as soon as the facilities of the new Clinical Research Hospital of the National Institutes of Health are available.

The Surgeon General is authorized under section 303 of the Public Health Service Act to provide training and instruction—directly or through grants to public and other nonprofit institutions—in matters pertaining to cerebral palsy.

There is also authority in the Surgeon General under section 314 (c) of the Public Health Service Act to make grants to States for State and local public health work, which authority would support grants to States for cerebral palsy control programs as part of their public health programs. In addition programs of health service and care for children afflicted with cerebral palsy are currently a part of the crippled children's programs organized by the States under the grant-in-aid programs of title V, part II, of the Social Security Act, administered by the Children's Bureau of the Social Security Administration in this Agency.

While it may be desirable to supplement generally present authority as respects research, fellowship, and training grants, to raise or remove present statutory limitations on the amounts of health grants to the States, and to perfect in certain other respects the provisions pertaining to these grants, the creation of additional categories for specific disease research, training, and control programs would only add to the complexity of the present grant-in-aid structure in this field and would be administratively undesirable.

The problems of persons afflicted with cerebral palsy are not confined to their health alone, as the bills seem to recognize in their references to educational research and training, and to restoration of persons afflicted with this disease. The education of these persons, particularly palsied children, and their vocational rehabilitation (including research and training in these fields), would fit more properly into programs currently conducted by the Office of Education and the Office of Vocational Rehabilitation in this Agency, than into the medical research and public health programs of the Public Health Service. Here again we believe that these problems can be more effectively handled through intensification, and where needed, extension and improvement of existing programs of the Office of Education and the Office of Vocational Rehabilitation, than by establishment of a new administrative unit and of a special program limited to persons afflicted by this particular disease.

For the reasons stated in the enclosed copy of the report of the Bureau of the Budget on S. 1538, that Bureau advises that the enactment of H. R. 1729, H. R. 3258, and H. R. 3645 would not be in accord with the program of the President.

Sincerely yours,

J. DONALD KINGSLEY, *Acting Administrator.*

EXECUTIVE OFFICE OF THE PRESIDENT,
BUREAU OF THE BUDGET,
Washington 25, D. C., May 9, 1949.

Hon. ELBERT D. THOMAS,
Chairman, Senate Committee on Labor and Public Welfare,
Washington, D. C.

MY DEAR SENATOR THOMAS: This will acknowledge receipt of your letter of April 14 inviting the Bureau to submit its views on S. 1538 to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of cerebral palsy, and for other purposes.

The bill would provide for a National Cerebral Palsy Institute in the Public Health Service and would authorize the Surgeon General to conduct, assist, and foster through grants-in-aid, fellowships, traineeships, etc., researches, investigations, experiments, and demonstrations relating to the cause, prevention, and methods of diagnosis and treatment of cerebral palsy.

Appropriations are available to the National Institutes of Health for work and research in the various fields of medicine and public health and in accordance with existing law, including section 301 of the Public Health Service Act, such funds are available on an over-all basis for research work relating to all the diseases and impairments of man. In the interest of a well-rounded research program as well as for reasons of sound administration it would seem undesirable to establish a separate institute for the disease of cerebral palsy or any other disease.

Substantial sums are also available for general health grants to the several States. In this connection it is significant that the President, in transmitting the budget for 1950, recommended appropriations sufficient to double the general health grants to States, raising them to $22,000,000, in order that the States in turn may extend and strengthen local health services. He also recommended that the present statutory limitation on the amount of such general health grants to States be removed from the Public Health Service Act, so as to authorize in later years the provision of larger amounts for the further improvement and expansion of local public health services, indicating his belief that this course of action is more desirable than adding new and separate grant programs or continuing the expansion of existing specialized health programs.

In the light of these comments, it is felt that enactment of the proposal would not be in accord with the program of the President.

Sincerely yours,

FRANK PACE, Jr., *Director.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., April 27, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letters of February 15, 1949, March 8, 1949, and March 23, 1949, requesting reports by the Veterans' Administration on identical bills H. R. 1729, H. R. 3258, and H. R. 3645, Eighty-first Congress, entitled "A bill to amend the Public Health Service Act to provide for research and investigation with respect to the cause, prevention, and treatment of cerebral palsy, and for other purposes."

The bills propose to establish a National Cerebral Palsy Institute in the Public Health Service and a National Cerebral Palsy Council for the principal purpose of improving the health of the people of the United States through the conduct of researches, investigations, public education, and demonstrations relating to the cause, prevention, and methods of diagnosis, treatment, and restoration of those afflicted by cerebral palsy.

The proposed program would be administered by the Surgeon General of the Public Health Service under the supervision and direction of the Federal Security Administrator and the Surgeon General would be given broad powers in carrying out the purposes of the bills. The National Cerebral Palsy Council would consist of the Surgeon General of the Public Health Service, or his representative, the Chief Medical Officer of the Veterans' Administration, or his representative, the Surgeon General of the Army, or his representative, the Surgeon General of the Navy, or his representative, the Chief of the Children's Bureau, or her representative, and 12 members appointed without regard to the civil-service laws, by the Surgeon General of the Public Health Service, with the approval of the Federal Security Administrator. The 12 persons appointed would be leaders in the fields of medical science, who have qualified as specialists in cerebral palsy, the fundamental sciences, education, or public affairs; one of these would be an individual who, himself, or herself, although otherwise qualified, is cerebral palsied, and one would be a registered nurse, qualified by experience with cerebral palsied patients. The Surgeon General of the Public Health Service would be authorized to utilize the services of any member or members of the Council in connection with matters related to the work of the Service for such periods, in addition to conference periods, as he deems necessary. The Council would act in an advisory capacity to the Surgeon General of the Public Health Service and with his approval would appoint subcommittees to deal with various phases of diagnosis, treatment, and training of cases of cerebral palsy.

The Surgeon General of the Public Health Service would be authorized and directed to make grants-in-aid to States, counties, health districts, and other political subdivisions of States, and to public and nonprofit institutions for the establishment and maintenance of programs for prevention, treatment, and control of cerebral palsy. This proposal is similar to existing law (42 U. S. C. 246) with respect to grants to States, counties, health districts, and other political subdivisions of States for the prevention, control, and treatment of venereal disease, tuberculosis, and heart disease. The Surgeon General of the Public Health Service would also be authorized to recommend to the Federal Security Administrator the acceptance of conditional gifts pursuant to section 501 of the Public Health Service Act (42 U. S. C. 219) for study, investigation, or research into the cause, prevention, or methods of diagnosis or treatment of cerebral palsy, or the acquisition of grounds for the erection, equipment, or maintenance of premises, buildings, or equipment of the Institute.

These bills propose to establish within the Public Health Service another institute designed to cover one individual segment of research in the field of medicine. The committee may wish to consider the advisability of the development of multiple institutes for research into specific diseases on the ground that it would tend to departmentalize research and investigation. Research in one problem very often leads to research in another and an institute confined to one narrow field of research might have a tendency to limit the vision of the workers.

Since the Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation except representation on the proposed National Cerebral Palsy Council, no comment other than the above is offered. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that office to the submission of this report to your Committee.

Sincerely yours,

O. W. Clark
(For Carl R. Gray, Jr., Administrator).

Mr. Priest. Our first witness this morning is Miss Ruth Tichenor.

STATEMENT OF MISS RUTH TICHENOR, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, INC.

Miss Tichenor. I have come here today not to ask for special privilege for a small group of citizens, but to plead in behalf of an entire "lost battalion" of Americans—the estimated 500,000 victims of cerebral palsy, more commonly known as spastics.

Back in 1943 I was a perfectly normal young woman of 26. Then, as the result of a cerebral hemorrhage, I lost all use of my left side, became the cripple whom you now see before you. My mother, then 65 years of age and a widow, was advised to have me committed to the home for incurables. Over and over I heard friends reason mournfully with her, "Who will take care of the poor soul when you are gone?" But she, believing in the power of her prayers and my own native courage, nursed me through the long illness and encouraged me in the difficult task of finding employment and becoming as nearly rehabilitated as was possible without the special treatment which we could not afford.

At first, in my despair at being unable to find remunerative work, to say nothing of playing the piano, hiking, bowling, and the dozens of activities in which I have formerly engaged, I felt as though I were the first person in the world to whom this terrible thing had ever happened.

The natural curiosity about my fellow human beings prompted me to look about, and I found that I was one of many. In popular parlance an accident is often defined as "something that happens to the other fellow." Perhaps mention of just a few spastics of my own limited acquaintance will convince you that a birth accident or cerebral accident in adulthood does not fall within the scope of this witticism, that this crippler has no respect for age, class or any of the other artificial classifications by which we catalog ourselves and our fellow mortals.

Bobby is about eight now. As the result of an injury at birth he has never learned to walk nor to use his little hands normally. His parents, people of very modest means, could not afford to enroll him in one of the few, very expensive schools for spastic children, and the teachers in the public schools feel that his presence among the normal youngsters would be too disturbing. So now he sits in the house with his mother or on the front porch playing fumblingly with his simple toys while the neighborhood tots whiz by on their roller skates or race to and from school. Mentally Bobby is a bright youngster, but he needs specialized training and treatment, the sort of care which has long been the accepted right of polio victims, but which is still denied to the vast majority of spastics.

Then there is the old Italian-American with whom I am on very special terms of friendship because, as he puts it, "You cripple just like me." (We are both suffering from handicaps, from hemiplogia, a one-sided paralysis.) Patsy was a strong, hard-working citizen until about the age of 50 when a cerebral hemorrhage disabled him. Then because of his age and handicap, he was forced to become a beggar; for a number of years he has been a familiar figure in our town. Over his uninjured shoulder he carried a worn canvas bag similar to that used by newsboys. Leaning heavily on his cane he hobbled from house to house, receiving here a piece of bread, there a few potatoes, until, having secured enough food to keep him alive for a few days he made his way back to his miserable shanty. When last I spoke with him a few weeks ago he was very happy because he had just been made the recipient of an income of $25 per month, and so could live without begging.

One of the most pitiable cases of cerebral palsy with which I have come in contact was related to me by the victim's mother. Mrs. Wilson was a country girl from a backward mountain community who had been reared to believe implicitly in the biblical injunction to "be fruitful and mulitiply and replenish the earth." She bore 12 children, all but 1 of whom died at birth before a doctor "just happened" to discover that a small growth on her pelvic bone was causing this wholesale slaughter of innocents. Now her only surviving child is a spastic, a boy of 25 who must have the constant care of a little baby. I would beg you gentlemen to ponder upon the grief of this mother who has undergone the agonies of childbirth 12 times and now in her old age has only the "comfort" of a crippled, almost idiot, son.

Those are just a few cases of cerebral palsy with which I have come in contact in a small West Virginia city. But perhaps they have served to emphasize the wretched plight of the thousands of spastics throughout our Nation, the great "lost battalion" into whose ranks many thousands more will be recruited unless we provide adequate facilities for research into this colossal social problem.

House bills 1729, 3258, and 3646 for research into the cause, prevention, and treatment of cerebral palsy are of the utmost importance in ameliorating the suffering of those presently afflicted and in reducing the number of future victims.

It is generally accepted that the cerebral palsied, once dismissed as incurables can be to a great extent rehabilitated by an intensive program of muscular reeducation, based upon the training of healthy brain cells to do the work of those which have been destroyed. Intensive research has also been undertaken in the field of preventive medicine. There remains only the task of elaborating this work and making its results available to the thousands who need help so desperately.

I plead with you in whose hands our fate lies to speed passage of H. R. 1729, H. R. 3258, and H. R. 3645, bills to establish the National Cerebral Palsy Act.

Mr. Priest. We thank you very much, Miss Tichenor. Perhaps we could get these figures from some of the medical authorities that may appear later as witnesses, but I wonder if you have an estimate of the number of persons in the country today who are suffering from one form or another of cerebral palsy.

Miss Tichenor. I believe that the estimated number, as quoted, is about 500,000. That is as close an estimate as I have here.

Mr. Priest. Thank you very much for your statement and your interest in this subject.

Our next witness will be Mrs. Rupert L. Dunn, president of the Montgomery County Cerebral Palsy Association.

STATEMENT OF MRS. RUPERT L. DUNN, PRESIDENT, MONTGOMERY COUNTY CEREBRAL PALSY ASSOCIATION

Mrs. Dunn. I am Mrs. L. Dunn, of 616 Albemarle Avenue, Takoma Park, Md.

Gentlemen, speaking in support of the National Cerebral Palsy Act since I am a lay person and a parent all I can do is present the point of view which is shared by many parents who have to live with this courage-curdling situation, day in—day out, year after year—till in desperation they are driven to seek help or assistance in any way possible for the afflicted child, often sacrificing family ties and other members of the family in this process.

The road of life is hard for anyone who is handicapped but how much greater for a little child who may have—not one but two or three handicaps, which is common in cerebral palsy, only the trained physician and devoted parents really know.

What chance has a child whose speech is affected—whose balance is none too good—or whose muscles are paralyzed—what has he to look forward to? To be able to think—yet not to speak—to want to run and play—yet stagger and stumble—to want some measure of happiness—yet to be ignored or cruelly hurt by normal children; that is what life has in store for a cerebral palsied child unless we extend a helping hand.

In some States recognition of the problem has resulted in increased grants-in-aid to handicapped children for special education and other services, and while this is a step in the right direction there is the great mass of preschool children and those not in any school who need these special services and who may never receive them unless something is done at all levels—National, State, and local.

Competent authorities claim that approximately 70 percent of these children are educable, but education for them must go hand in hand with physical rehabilitation, for speech education physiotherapy and occupational therapy are so often required in many cases. The average workingman cannot afford to pay for the highly specialized treatment needed by these children and unless assistance is available through charitable or voluntary agencies the child does not have the opportunity for these services.

With the advent of the wonder drugs with which modern medicine combats disease—a higher percentage of these children may be expected to live—posing a greater problem as the years go by.

What about our taxpayers? It's true this National Cerebral Palsy Act will cost money—all health services cost money, and in the case of these cerebral palsied it will be money well spent; it is much better to train them to be self-supporting or partially self-supporting, than to have the taxpayers support them completely for all of their natural lifetime in State or other institutions.

While we hope and pray that a way may be found to give these cerebral palsied a sense of belonging and a sphere of usefulness somewhere, somehow—it is our duty to future generations to face this problem and to do it now and to provide the financial wherewithal for research, prevention, treatment and cure if possible.

Mr. Priest. We thank you very much, Mrs. Dunn.

The next witness on the subject of cerebral palsy will be Mr. Paul A. Strachan, president of the American Federation of the Physically Handicapped, Inc.

STATEMENT OF PAUL A. STRACHAN, PRESIDENT, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, INC.

Mr. Strachan. Mr. Chairman, my name is Paul A. Strachan. I am president of the American Federation of the Physically Handicapped.

At this moment I wish to discuss briefly the various bills, H. R. 1729, H. R. 3646 and H. R. 4258, to establish a national cerebral palsy act.

Since I have a prepared statement, I am going to turn it in to the committee and discuss this problem rather informally and briefly.

Mr. PRIEST. Your statement will be made a part of the record at this point.

(The statement referred to is as follows:)

STATEMENT OF PAUL A. STRACHAN, PRESIDENT, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, ON H. R. 1729, H. R. 3258, AND H. R. 3646, TO ESTABLISH THE NATIONAL CEREBRAL PALSY ACT

Mr. Chairman, H. R. 1729, introduced by Mr. Priest, H. R. 3258, by Mr. Biemiller, and H. R. 3646, by Mr. Battle, to establish a national cerebral palsy act, have the common objective of endeavoring to provide a means whereby we can deal with this dread and crippling disease, and which bills, we firmly believe, are among the most important measures before the Congress today.

We believe that the Federal Government must take leadership in this matter to insure continued and continuous research into this vital field of human needs and values. The difficulty today is, that treatment of severe cases of cerebral palsy costs so much that they are beyond reach of those in medium or humble circumstances. For example, who, on an average, could afford to pay, say $250 per month for treatments, with subsistence and lodgings additional, approximating $150 more? And since medical science, as yet, has found no cure for cerebral palsy, it is necessary to approach the problem, medically, on another plane—that of attempting to educate latent muscular power, so as to make an off-set.

Among our members are many cerebral palsied. Some of them, I hasten to state, in great measure, have conquered their disability. Among them are graduates of great colleges. That is a surprise to many people who do not realize that cerebral palsied may, in fact, become great students and be fully competent to grapple with many phases of our economic and social life. In fact, on that point, at our national convention, last August, the visitor from India, Dr. Wilfred P. Singh, who had been a probation officer and welfare worker, and who stated that the physically handicapped population of India is estimated to be in excess of 125,000,000—also stated that, from what he had observed of the handicapped in action at our convention, he would return home ashamed of the treatment he had previously meted out to cerebral palsied and other severely disabled, as he was convinced that they have great potentials and abilities, and, henceforth, he would see that they are treated as any other persons. And, that under no circumstances would he, henceforth, classify cerebral palsied as being mentally handicapped.

We especially direct the attention of the committee, Mr. Chairman, to the title, National Cerebral Palsy Council. Since this bill was drafted in collaboration with the greatest medical specialists on cerebral palsy in the United States, experts whose knowledge is far beyond that of the physicians in the Public Health Service, or the so-called rehabilitation experts in the States—we point out the absolute necessity of maintaining the council set-up, intact, because the various subcommittees were proposed to meet a great need, and since, as stated, the eminent specialist who collaborated on this phase, all have had their turn at bat and all set up fundamentals of research in this field, which have never been used before in any Government agency, Federal or State, or bloc, we insist Mr. Chairman that all this is highly important and by all means should be retained in any legislation which may come out of this committee, bearing upon cerebral palsy.

We have expressed our objections to lumping various diseases under one heading—cerebral palsy, epilepsy, arthritis, rheumatism, multiple sclerosis, etc., unless there is a blueprint of what is to be expected in each field of research. We respectfully call upon the committee not to omit from any final legislation which the committe may approve, the means of showing just what the legislation does; how much money is to be expended, and who is to be responsible for what—thus removing some of the smoke screens which have been thrown around similar enactments in the past.

This measure has been endorsed by representatives of more than 35,000,000 citizens in organizations of industry, labor, business, veterans, farms, women, fraternal, civic, educational, scientific and professional, etc.

We hope, on behalf of the 600,000 cerebral palsied, this committee will act favorably on this bill. And, to enable the committee to have the benefit of the experience of one who is, herself, cerebral palsied, I am introducing to the committee, Miss Ruth Tichenor, of Fairmont, W. Va.

Before leaving the stand, I wish to file statements which have been received from Doctors Herman Kabat, M. D., and Winthrop Phelps, M. D., eminent specialists in the cerebral palsy field, as well as a statement from Miss Lily Mae Clawson, president, Spastics of America, and Miss Ruth E. Loyster, Secretary of our Ypsilanti, Mich. lodge, victims of cerebral palsy.

Mr. STRACHAN. I should like to call attention in the proposed bill to the committee set-up which has been outlined.

For the benefit of the committee, Mr. Chairman, I want to say that I have made an extensive investigation and have found that there are some 17 top-bracket specialists in the medical field in cerebral palsy. I presented to each one of these specialists a copy of the bill and asked them to tear it apart—to find out what is wrong with it. I told them to remember that this is not to be anything other than medical research; it is not a rehabilitation measure. One thing that I gave express directions on was the establishment of a National Cerebral Palsy Council.

Mr. Chairman, I am sure that you and other members of the committee can vouch for one thing, and that is the city of Washington has more so-called advisory committees to the square foot than any other city on earth. I know because I am a member today of six of them, and some of those committees have not met in 2 years, and neither advise nor commit.

I want to see a real effort made in this cerebral palsy matter, and I am sure that the committee joins me in that hope.

I am pointing out that in Government, unfortunately, we do not have the money to pay for the kind of specialists who are experts in this dread disease. I am sure that these men ordinarily would command in practice from $150 to $200 at a crack and they book a business of from $50,000 to $150,000 a year. The reason I mention that is because I did not, Mr. Chairman, go out and collar the first M. D. that I met, but I made a conscientious effort to get the facts from the top-bracket people of this country.

I have been told it is the committee's policy to consider the necessity of dealing with all these medical research bills under one head. I am not opposed to that, but I do insist on this: I have seen too much evidence of the intent of Congress completely negated by either ignorance or improper administration, and therefore I urge in this instance that the Congress preserve in each case a qualified committee set-up.

A cerebral palsy expert would not necessarily know anything about arthritis. A committee should be set up so that it thinks it has a job to do, and there should be some means of checking up to find our whether or not it does that job.

I have been on many committees in Government where we would meet and just say, "Boys, what are we here for?" And if there was not developed a satisfactory reason for being there, they would quit on the spot.

I urge you to consider the necessity of committee and subcommittee set-ups, such as we have outlined here on the cerebral palsy bills to cover such other illnesses that might be brought in. It may make the omnibus measure a little longer, but it will at least give us a lead on what we want to do.

I am absolutely opposed to throwing all these things into one pot and stirring them up together, because that is wrong.

I checked in the medical dictionary and find this condition, that there are something like 4,800 recognized diseases. One human brain could not possibly encompass the range of knowledge required for all of them. We might find one disease, heart disease, that in itself would necessitate a whole field of specialists.

Very well, we are coming to specialization now. For example, the Public Health Service surgeons were asking last week when the Advisory Committee on Leprosy met last, and they had to admit that they had not met since December 1947. I submit to you, Mr. Chairman, that situation is wrong. Either we need a committee or we do not need one. If we do need one, give it a job and see that it has the means to do the job.

I am not going to take up the time of the committee today in any lengthy dissertation, but I would like permission to file for the record a statement from the Cerebral Palsy Association, Inc., 304 Southwest Eighth Avenue, Miami, Fla.

Mr. Priest. It will be inserted in the record at this point.

(The statement referred to is as follows:)

Specific Needs To Be Used in the Formulation of Legislation to Benefit the Cerebral Palsied

(Submitted by Cerebral Palsy Association, Inc., Miami, Fla.)

1. A law requiring all cerebral palsied individuals to be registered with their State departments of health and education as soon as diagnosis is made.

2. All physicians, hospitals, health, and educational agencies and all institutions should be required to report the vital statistics on the cerebral palsied they are now serving.

Such registration will determine for each community: (*a*) Type of treatment necessary, (*b*) personnel required, (*c*) how many facilities are needed.

3. Diagnostic centers established as a service in hospitals, where patients can be hospitalized, whose educability and potentialities can best be determined by specialists.

4. Traveling diagnostic clinics for rural areas, originating from diagnostic centers staffed by: (*a*) Specialists—a doctor experienced in cerebral palsy, (*b*) physiotherapist, (*c*) occupational therapist, (*d*) speech correctionist, (*e*) social worker, (*f*) orthopedic appliance maker. Such mobile units should remain for an announced period of time in each area at stated intervals; should have large trailers partitioned off into examination and therapeutic treatment rooms.

5. Day and evening out-patient clinics in urban centers, staffed by a team of medical and therapeutic personnel fully qualified in treatment of cerebral palsy: (*a*) Provide instructions to parents in administration of therapeutic treatment of patient at home, (*b*) evening clinic for those who are employed, and training of personnel.

6. Training of medical personnel to provide accurate diagnosis and prescribe new techniques of treatment that have been developed.

7. Medical schools be required to give more detailed specialized instruction on causes, diagnosis, and treatment of cerebral palsy so that more pediatricians and general practitioners can promptly recognize individuals so afflicted: (*a*) Young doctors be given fellowships and encouraged to take special training in (1) neurology, neurosurgery, orthopedics, orthopedic surgery, and actually to experience working with cerebral palsy individuals under competent medical supervision at recognized schools and institutions for the cerebral palsied; (2) psychiatrists and psychologists should develop psychometric tests to accurately measure and diagnose the aptitudes, abilities, and capabilities of the cerebral palsied individual.

8. Scholarships to foster specialized training in cerebral palsy of: (*a*) Physiotherapists, occupational therapists, speech therapists, social workers, and psychometrists.

9. Nursery, kindergarten, and elementary schools available to as many cerebral palsied children as possible to obtain necessary educational, therapeutic, social, and prevocational training.

10. Ample funds to continue research should be made available to medical scientists to evolve preventive techniques and better methods of treatment.

11. Participation of family: To assist financially within family means to support child.

12. For the adolescents: Continued education and therapeutic treatments, vocational guidance, training and follow-up; psychotherapy and recreational facilities for social contacts, training and employment.

13. Program of public education: (*a*) to get public to understand and accept the victim; (*b*) demonstrate the needs; (*c*) bring cerebral palsy to the attention of physicians, therapists, teachers, social workers, and so forth—so when choosing a career they may consider cerebral palsy as well as more familiar afflictions; (*d*) stimulate research; (*e*) press for more effective functioning of already existing legislation; (*f*) arouse public interest toward enactment of new legislation both State and Federal; (*g*) stimulate public giving; (*h*) awaken industry to the labor potential of the rehabilitated cerebral palsied adult; (*j*) encourage organization of associations of parents of the cerebral palsied.

14. Rehabilitation and residence (custodial) schools—one each in the five districts of the Florida Crippled Children's Commission: (*a*) Based on present population and using Dr. Phelp's formula (7 cerebral palsied out of every 100,000 population in each year) there is estimated 9,750 cases of cerebral palsy to age 65; 6,000 cerebral palsied to age 40; and 3,000 cerebral palsied to age 20 in Florida alone: (1) Of these one-third are feeble-minded; (2) of these two-thirds are educable; (3) of the educable group, 25 percent or 500 cases are severe cerebral palsy cases requiring custodial care; (4) the one-third feeble-minded, or 1,000 cases, should be placed in separate quarters; (5) the 50 percent or 1,000 educable cases which includes the preschool child, should be provided for by extended public schools systems. (*b*) For those cerebral palsied severely handicapped and requiring long periods of specialized hospital training and care—where the patient can receive medical, nursing, hospital, physiotherapy and related care academic and vocational education, reasonable warmth and affection and an opportunity for social life with others. Such a place would be for those so severely and permanently handicapped that they cannot be cared for in their own home nor in hospitals designed for short term care—a place where the child will be happy and will not have to be sent to our already overcrowded institutions for the feeble-minded—a place for those children who become orphaned or victims of broken homes and who cannot be placed in a satisfactory foster home.

Above provisions included in legislation would act as a safeguard and the rehabilitation as self-supporting citizens would tend to reduce the large number of cases now needing help.

Mr. STRACHAN. I would like to present for the record at this time a statement of Dr. Herman Kabat, M. D., Permanante Foundation Hospital, Oakland, Calif.

Mr. PRIEST. It will be inserted in the record at this point.

(The statement referred to is as follows:)

STATEMENT OF DR. HERMAN KABAT, M. D., KABAT-KAISER INSTITUTE, OAKLAND, CALIF., FAVORING H. R. 1729, H. R. 3258, AND H. R. 3646, BILLS TO ESTABLISH THE NATIONAL CEREBRAL PALSY ACT

(From American Federation of the Physically Handicapped, Inc.,
Washington 4, D. C.)

The problem of cerebral palsy is an urgent and very important one. These patients suffer from infancy from stiffness, paralysis, and incoordination of voluntary motion which affects their ability to walk, use their hands, and speak. Most of these cases are of normal intelligence and have a normal life expectancy. The condition is due to damage to the brain from injuries of birth or shortly thereafter, as well as certain infections in infancy and maldevelopment of the brain.

The number of patients with cerebral palsy, both children and adults, is not accurately known but is comparable to and may exceed the number of victims of infantile paralysis. While there has been great public interest and extensive medical services for patients with poliomyelitis with very gratifying results, the very similar problem of cerebral palsy has been terribly neglected. The methods of muscle reeducation which have made possible recovery of function and rehabilitation to such an extent in poliomyelitis are applicable with some modifications to patients with cerebral palsy with equally satisfactory beneficial results. In fact, patients with chronic paralysis from cerebral palsy make a more complete recovery through physical therapy than is possible in chronic cases with a similar degree of paralysis from poliomyelitis. The great advances in the medical science of rehabilitation such as the program for paraplegics during and since the war, should give a new impetus to the rehabilitation of patients with cerebral palsy. Much remains to be learned both in fundamental and applied medical science in this field and the proposed National Cerebral Palsy Institute should make a significant contribution toward this end.

Cerebral palsy is not a single disease but is a group of diseases having in common brain injury in infancy. The causes are many and varied and many investigations must be made before we will have the knowledge to lay the path toward the ultimate prevention of this tragic condition. Research sponsored under the proposed bill would provide for investigations that should lead ultimately to a great decline in the incidence of this disease.

Equally as important as the proposal for scientific investigation are the sections of the bill calling for demonstration projects and control grants. The reason for this is that we now have within our grasp the means to do a relatively effective job of rehabilitating patients with cerebral palsy but this knowledge is not widely enough disseminated and the tremendous possibilities for recovery are not known even to professional people such as physicians. Therefore, demonstration projects would serve a very useful purpose in immediately calling attention to the medical and technical advances already made in order to raise the level of treatment and rehabilitation without delay throughout the country. The number of trained professional personnel of all types for this purpose is also woefully inadequate and must be provided before such a program can go into full operation.

I heartily endorse the National Cerebral Palsy Act and urge that it be passed by the Congress without delay and that generous funds be made available to carry out its purposes.

Mr. STRACHAN. I would like to insert in the record at this time a statement from Dr. Winthrop M. Phelps, M. D., 3038 St. Paul Street, Baltimore, Md.

Mr. PRIEST. It will be inserted in the record at this point.

(The statement referred to is as follows:)

STATEMENT OF DR. WINTHROP M. PHELPS, BALTIMORE, MD., FAVORING H. R. 1729, H. R. 3258, H. R. 3646, TO ESTABLISH NATIONAL CEREBRAL PALSY ACT

I feel that cerebral palsy, being specifically a brain condition, can have so many and widely distributed effects that it has to be considered as an entity in any program.

Thus arthritis, as a disease of the joints, never affects speech unless the jaws are involved and then it would only affect it slightly and in a mechanical way. Arthritis has no effect on the mentality and is not very often a condition which requires special education since it is very rarely present in children. Certainly there are not enough children with arthritis for any special program to be set up for them. They could be handled in special schools for the orthopedically handicapped very easily since in them there would be no tendency to any specific necessity for special education.

Epilepsy is a crippling disease only in the sense that it interferes with the reliability of the individual's behavior and, hence, placement possibilities are more limited because of this. There are many types of activities in which the epileptic can work satisfactorily and employment is by no means closed to him. With regard to his education, there are some evidences of mental retardation in some of these children, but in the majority the educational problem is simple. There is no involvement whatever of the motor system and no crippling with regard to walking or speech or the use of the arms.

Multiple sclerosis is a disease of adults and is progressive, becoming worse with time with remissions of improvement and then return of the condition. It is, therefore, also a problem of adults and one which is involved with considerable physical handicap. Plans for education in most cases would not be necessary since the educational phase has been completed by the time of onset.

Poliomyelitis, for example, is a cord disease, and hence does not affect the speech or sight or hearing.

In cerebral palsy there can be, in addition to the crippling of the arms and legs, difficulties with sight, hearing, and varying degrees of mental retardation in a small percentage of conditions. They, therefore, not only need physiotherapy and occupational therapy and speech therapy, but also treatment by drugs and surgery at times and special educational set-ups such as those used for the sight conservation in certain instances and the hard of hearing in others. This whole group of difficulties has to be considered in every cerebral-palsied child to some degree, and therefore the problem is that of the total child rather than a crippled arm or leg. The program has to be carried out over a long period of time in order to train the child as his abilities normally increase with age. The educational and physical restoration programs must parallel each other in order to obtain the best results.

The total problem of chronic conditions is one which can only make the best progress if each condition is considered as an entity and plans made accordingly for it.

Mr. STRACHAN. I would like at this time to submit for the record a statement of Miss Ruth E. Loyster, past president, Lodge 76, American Federation of the Physically Handicapped.

Mr. PRIEST. The statement will be inserted in the record at this point.

(The statement referred to is as follows:)

STATEMENT OF MISS RUTH E. LOYSTER, PAST PRESIDENT, LODGE 76, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, YPSILANTI, MICH., ON THE PROPOSED NATIONAL CEREBRAL PALSY ACT

Mr. Chairman, with respect to research into the cause, prevention, and treatment of cerebral palsy, H. R. 1729, H. R. 3258, and H. R. 3645 are comprehensive and far-reaching bills which should be endorsed. The need for such national legislation cannot be doubted when one considers such statements as those made by a well-known authority (Dr. M. A. Perlstein, the Problem of Cerebral Palsy Today, p. 16) that the facilities available today for the care of cerebral-palsied children are by type spotty, uncoordinated, and unstandardized; and by capacity they are at least 90 percent inadequate. Although Detroit has two schools for crippled children, the cerebral-palsied child is not readily accepted. Instead parents are advised to send their child, regardless of his mental abilities, to the Lapeer State Home which is the Michigan institution for the feeble-minded and which provides only custodial care.

Four points which these three bills on cerebral palsy provide should be stressed. First, these bills provide for study of the causes and prevention of this condition. While this country can proudly show a decline in the infant mortality rate, little is said about the physical conditions of the babies who survive. We cannot be satisfied that babies live. We must see that they are born physically and mentally normal. Yet today cerebral palsy is said to be increasing. Just one example, and others could be cited, of what the study of prevention might mean is a statement made by one authority (Dr. M. A. Perlstein, the Problem of Cerebral Palsy Today, 1947, p. 48) that the prevention of anoxia (lack of oxygen) at birth would perhaps eliminate one-half of the cerebral-palsied cases.

Second, the provisions made for treatment and its study are essential, for it is known that under proper treatment new nerve pathways can be developed to take over much of the function of the injured ones. Still, today many parents are either ignored by their physicians when they seek help and advice or are told to send their child to an institution and go home and have more children.

Third, the fact that a cerebral-palsied, who is otherwise qualified, will be a member on the National Cerebral Palsy Council means that a gap can be narrowed between the physician and other professional personnel dealing with the cerebral-palsied and the cerebral-palsied themselves, their parents, and laymen. Other things being equal, no one can understand the problems of the so-called spastic better than one so handicapped. Too, often the specialists in this field become so interested in the medical aspect that they forget that they are dealing with living human beings. A cerebral-palsied on the Council could help bring about a better understanding of the feelings of the spastic to the specialist and also explain the attitudes of these specialists to the cerebral-palsied.

Fourth and equally important, these bills would become a part of the Public Health Service Act. In defining a public-health problem as (1) any condition which is a widespread cause of morbidity, mortality, or both; (2) knowledge if applied could cure or alleviate the condition; and (3) knowledge not being applied satisfactorily, it is easily understood that with the large number of so-called spastics in the United States who receive little or no help, cerebral palsy is definitely a public-health problem.

To become personal and give my own case, I become horrified when I stop to think what could have happened to me had it not been for my parents' understanding and my own feeling of security during my childhood. To begin with, if, among other things, a certain drug had not been used at the time of my birth, I might never have had cerebral palsy. But since I was injured at birth, this did not make my parents accept the suggestion of one physician that nothing could be done for me and that I could be committed to the Lapeer State Home, nor did my parents accept the advice of another physician that, since I looked happy and well cared for, they should just keep me at home. Instead, they finally found an orthopedic school where I could receive some physical as well as educational training. While, after finishing the grades, provisions for physical training lagged, I had the opportunity to continue my academic studies, not because the teachers in the orthopedic school encouraged me to do so but because my parents arranged for me to continue my schooling, and this is a long, hard fight.

I only mention my case to give another example of the lack of knowledge and understanding among the professional people who come in contact with the spastic, and of the necessity of national legislation for cerebral palsy. Surely every individual who has cerebral palsy should have the right to receive treatment and rehabilitation so that he may learn to use his abilities to the fullest of his capacity. Surely future generations of infants and parents should be assured that prevention of cerebral palsy is being attempted. This proposed legislation on cerebral palsy provides a means toward reaching this goal. Thus it must become law.

Mr. STRACHAN. I would like to submit for the record at this point a statement by Miss Frances M. Giden, research assistant to the director, Institute of Logopedics, Inc., Wichita, Kans.

Mr. PRIEST. It will be inserted in the record at this point.

(The statement referred to is as follows:)

TESTIMONY OF FRANCES M. GIDEN SUPPORTING THE GENERAL PURPORT OF THE PROPOSED NATIONAL CEREBRAL PALSY ACT, H. R. 1729

Gentlemen, I am research assistant to the director at the Institute of Logopedics in Wichita, Kans., a nonprofit voluntary health organization, engaged in the corrective training of persons with all types of speech defects, including those having cerebral palsy. Obviously, I myself have been born with this condition. I hold, however, three college and university degrees—bachelor of arts, Hunter College; bachelor of laws, Fordham Law School, where I was editor in chief of the Fordham Law Review; and master of arts in vocational rehabilitation, New York University. I have approximately 10 years' experience in working among the physically handicapped in general and the cerebral-palsied in particular. Prior to my employment at the institute I was an active participant in the cerebral-palsy movement in my home State of New York, which movement has most recently resulted in the first national convention on cerebral palsy and the newly formed National Foundation for Cerebral Palsy.

I appear before you today as a representative of Dr. Martin F. Palmer, director of the Institute of Logopedics, head of the department of logopedics, University of Wichita, and recently president of both the American Speech and Hearing Association and the Kansas Council on Children. Dr. Palmer asks that his regrets be conveyed to this body, since prior commitments have rendered it impossible for him to attend this hearing in person.

Dr. Palmer is wont to say that cerebral palsy is an impossible problem and any attempts at rehabilitation or education are absurd. From the standpoint of logic this is perfectly true. Cerebral palsy is a disorder of the central nervous system, in which damage to the brain sometimes before, during, or after birth results in impairments of locomotion, use of hands, speech, and ofttimes other sensory and motor defects. Heredity plays little or no part in causing this condition and as yet there is no medical or surgical treatment which is entirely successful in its correction, let alone its cure. Modern science has uncovered few new facts concerning the working of the human brain and thus medical papers on the subject written in the middle of the last century are still very "modern" in their concept and precept of this condition. For many years, children born with cerebral palsy have been classified as feeble-minded because their appearance, uncoordinated and unrelaxed as it is, is the prototype of the imbecile or idiot and because there is no adequate means of testing their inate intelligence due to the barriers of communication which result from the multiple handicap. Like many other old wives' tales which have shrouded the true nature of the condition for the past 50 years this concept has been substantially refuted by every leader in the field today and by the performances of those cerebral palsied individuals who with proper care, treatment, education, and vocational guidance and placement have found their role as contributing citizens of the community.

This, in its most general terms, is the situation faced in dealing with persons who have cerebral palsy. It might be well to add at the outset that cerebral palsy is not exclusively, or even mainly, a medical problem. It is a social problem—a problem in human relations wherein the presence of severe and multiple physical handicaps imposed upon a human being render the ordinary factor of daily living—education, social living, self-care, self-support, and acceptance by society—more difficult to attain than they are for the average citizen of our Nation.

What can we do about this condition? How can the Federal Government help equip its 294,000 cerebral palsied citizens under the age of 35 who can be benefited, so that these individuals may share the same privileges and responsibilities which are afforded every human being within our Nation?

H. R. 1729 proposes one method of doing this. Despite inaccuracies in medical knowledge and other points of issue, it outlines, in its most general terms, the over-all national plan as proposed by professional workers in this field today. It recommends the establishment of a National Cerebral Palsy Institute for the care, treatment, and training of cerebral palsied persons, for the training of personnel who will administer such care, treatment, and training, and for research in prevention, diagnosis, treatment, and "restoration" of the cerebral palsied. No one conceives even remotely that this Institute will serve in any other manner than as a model training center for such children and as a personnel training and research clearinghouse for the Nation. This is most direly needed. It is the foundation of all future work among this group of the population. Despite all the things that are not yet known about the condition, enough is known to rehabilitate these persons to reasonably normal lives provided that there is adequate qualified personnel in every field of medical, educational, vocational, psychological and social endeavor. In general, adequate qualification would mean such complete knowledge of their own specialty and of the condition of cerebral palsy that they can assimilate the two to the maximum benefit of the individual.

Personnel needs in this field have yet to be estimated. Most roughly they can be described in the following manner: The basic team that works with the child, the persons who are directly charged with carrying out the rehabilitation program on the front line, are the physical and occupational therapists and the logopedist. Each worker in these three basic professions can successfully care for about 20 individuals, and then only under supervision. In addition, it can never be forgotten that the child with cerebral palsy is first, last, and always a child—a human being. He needs the same medical attention as any other child, in addition to treatment for the motor and sensory defects caused by the lesion to the central nervous system. He must be educated. He must be guided, trained, and placed in a vocation through which he might become, at least, partially self-supporting. He must be guided spiritually and psychologically so that he and the world about him can live with his physical defects. Opportunities for play and social living must be afforded to him. Over and above all this, the child lives on while he is receiving all these things. There must be people to feed him, to dress him and undress him until he learns to do these things for himself—people to lift him on and off the treatment tables, people to care for him at night. Parents must be trained not only in carrying through the rehabilitation program, but in rearing the deviant child to maturity. There must be administrators, business managers, and public relations counselors to carry the details of such a program, and to make society ready to accept these people after the workers have done their part to make the cerebral palsied individual acceptable to society. And these are but a few of the services every individual needs as he goes through life in the world of today. The services of the physio and occupational therapists and the logopedist, essential as they may be, are far from sufficient. The services of the following must also be available to the cerebral palsied: The orthopod, the pediatrician, the neurologist, the internist, the otolaryngologist, the psychiatrist, the clinical psychologist, the social worker, the classroom teacher, the vocational teacher, the dentist, the educational and vocational counselor, the job placement expert, the brace maker and special equipment builder, the recreational director and toy counselor, the dietitian, the housemother, to give but a partial list.

Moreover and more important to the understanding of the true nature of the question before this committee is the fact that over and above the highest academic and personal qualification in his respective specialty, each person working with these individuals must have additional training and clinic experience in cerebral palsy to qualify in this area. This is a fact universally recognized in all professions concerned with this problem. It cannot be overlooked or slighted in any consideration thereof. And, since each contributing profession is so highly specialized, one specialist cannot completely understand in every detail the nature of the others' work in this field. And therein lies the fundamental weakness of H. R. 1729.

Before a National Cerebral Palsy Institute or any other plan involving bricks and mortar can be discussed, before personnel can be begun to be trained, before research can be outlined, before anything is really done, there must be a plan—a detailed plan of operation. Qualified persons in each of the contributing specialties must blueprint the needs of their specific areas in the total problem—what is involved in training their type of personnel in this field, what is the nature of their contribution in detail and what is to be expected in detail from such contribution, and what further knowledge they must uncover to make that contribution greater. Anything done before such information is available is wasted time, effort, and public funds. Only when such committees of leaders in the various contributing specialities have reported on these items will there be a true definition of what the problem is and what can be done to meet it.

Mr. STRACHAN. Finally, I would like to submit for the record a statement by Miss Lily Mae Clawson, president, Spastics of America, Inc., Wichita, Kans.

Mr. PRIEST. It will be inserted in the record at this point.

(The statement referred to is as follows:)

STATEMENT OF LILY MAE CLAWSON, PRESIDENT, SPASTICS OF AMERICA, INC., WICHITA, KANS., RE H. R. 1729, H. R. 3528, H. R. 3546, NATIONAL CEREBRAL PALSY ACT

This statement is presented to urge immediate passage of H. R. 1729, H. R. 3528, and H. R. 3645, the National Cerebral Palsy Act. I am writing as a person who has cerebral palsy, as the president of Spastics of America, Inc. (a national organization composed entirely of cerebral palsied persons), and as a member of the American Federation of the Physically Handicapped.

The plight of the cerebral palsied is desperate. Through the wide contacts which I have with spastics (the popular term for the cerebral palsied) over the United States, I am very much aware of the appalling lack of medical and educational facilities available to this group of handicapped persons. It has been estimated there are approximately 500,000 spastics in this country; it is quite possible there are many, many more.

Every spastic I know has at one time or another been considered feeble-minded. My own parents were advised to place me in an institution for the mentally deficient, but fortunately they recognized a good mind when they saw one and gave me every medical and educational advantage. I have a university degree and have been self-supporting ever since I graduated from college. But I am one of the lucky ones. While most parents of spastic children do not accept the verdict of mental deficiency, there are many who do and allow their children to be committed to institutions for the feeble-minded, not knowing they are sending their children into a living death.

Recently I visited a State institution for the feeble-minded. Of the several thousand inmates I saw there, at least half are spastics. These people are all herded together like animals; there is no normal family life there. The diet consists of beans, bread, potatoes, and milk. Some of the spastics are so badly handicapped their legs are wrapped around their necks. Nothing is being done to alleviate their condition. Although there is a hospital on the premises, the latest medical discoveries are not used. Penicillin costs more than a human life. There are no recreational facilities and few, if any, educational facilities. It was very apparent that only custodial care is practiced in this institution.

Another shocking demonstration of the lack of facilities for spastics occurred in Detroit, Mich., a few weeks ago. A 29-year-old spastic girl, unable to walk or talk, was shot and killed by her father. This was done because the father was ill, and in the event of his death, there would be no place to send the girl other than to an institution for the feeble-minded.

It is obvious that the father felt his daughter would be better off dead than she would be spending the rest of her life imprisoned with the mentally defective. This tragedy could have been averted if there were proper facilities for the care of the cerebral palsied.

Neither institutional care nor mercy killing is the answer. We spastics do not want charity, but merely the opportunity to become useful, self-supporting citizens. We of Spastics of America, Inc., believe that many of the problems facing the severely handicapped spastic can be solved through the establishment of a home-school where spastics may live in comfort and security and at the same time be taught trades and vocations in order that they may become at least partially self-supporting. Most of us can be helped a great deal through the proper medical treatment, but because it is very expensive, few parents can afford it for their spastic children. Often only a slight physical improvement means the difference between complete dependency on someone else and partial self-support. For example, therapy directed toward teaching a severely handicapped spastic to type can open up a new world for that person.

The National Cerebral Palsy Act must become law. The welfare of the 500,000 cerebral palsied in the United States depends greatly on its enactment. Therefore, I urge the Congress to act upon this vital question immediately.

Mr. Priest. We thank you very much. I assure you that the committee will take fully into consideration the suggestion that you made with reference to committees in case an omnibus bill should be decided upon. Without objection we will insert at this point statements of Dr. Rene Cailliet of the Kabat-Kaiser Institute and of Mr. Kenneth R. M. Gillespie of the District of Columbia Society for Crippled Children.

(The statements are as follows:)

Cerebral Palsy Bill—H. R. 1729

(Statement presented by Rene Cailliet, M. D., medical supervisor, Kabat-Kaiser Institute, Washington, D. C.)

This statement is voluntarily offered in direct support of passage of H. R. 1729, titled "Cerebral Palsy Bill." Its endorsement and enactment as stated within the bill are strongly recommended.

Cerebral palsy today presents a serious problem from both the social and economic aspects, as well as a medical problem. The incidence of cerebral palsy is not known accurately due to faulty studies, but it is estimated to number in the tens of thousands. It is a disease whose cause is as yet only partly understood, but its incidence is widespread regardless of race, color, or creed. The program for research in cerebral palsy must, therefore, fall into intensive research as to causation so that prevention as well as treatment will eventually be possible.

The treatment of cerebral palsy is an over-all type of medical treatment and requires high specialization. Due to this fact it has been neglected by all the accepted specialties of medicine with very few exceptions. The problem is at present handled in this country by relatively few organizations and even fewer doctors, and the very fact that multiple specialties are usually called in makes the cost of treatment impossible for the average family. This cost of treatment is made even more expensive due to the prolonged nature of the known and accepted type of treatment today.

Due to the paucity of research and the inadequacy of interested as well as informed medical personnel, and due to the extreme lack of existing facilities for coordinated treatment, Government facilities, such as proposed in H. R. 1729, are a definite necessity so that the research program and the dispersion of knowledge gained therein will be made available to all the branches of medicine as well as to all the economic stations of life.

It seems undesirable to me that a bill for cerebral palsy and support thereof should be lumped with other bills of a medical nature. This fact is stressed because the treatment of cerebral palsy includes pediatrics, internal medicine, surgery of a specialized nature, psychological testing of a specialized type, psychiatric understanding, and, above all, a rehabilitation approach that is highly specialized and even individualized. To include this study with other so-called similar neurological diseases would deny the patient the over-all program considered essential.

This statement is therefore made in serious hopes that early passage and efficient administration will supply a serious medical, social, and economic problem that is now inadequately handled.

Statement of Kenneth R. M. Gillespie, Former Vice President of the Parents' Association of the District of Columbia Society for Crippled Children

Mr. Chairman and gentlemen of the committee, my name is Kenneth R. M. Gillepsie, former vice president of the parents' association of the District of Columbia Society for Crippled Children. I feel highly honored in being permitted to appear before this committee today not only because of your courtesy in extending this favor but also because of the importance of the subject at hand.

I have read the hearings on S. 1538, a similar bill to the one under consideration here, which provides a program of research and aid for the cerebral-palsied. While a measure of evidence is embodied therein, a number of cardinal points have, inadvertently perhaps, been omitted.

I, therefore, first of all, wish to refer you to a doctoral treatise of Leon S. Gordon, practicing physician and psychiatrist of this city, entitled "Intracranial Hemorrhages of the New Born." In this work Dr. Gordon has made an exhaustive search into the history of cerebral palsy from a medical-research standpoint and the results of his own investigations on the subject as well as of many others who have ventured into this field are included therein. From Dr. Gordon's thesis I wish to point out to you at least two astounding revelations:

First, out of 150 stillbirths taken at random, 123 died as a result of brain injury (cerebral palsy).

Second, based on examinations of the spinal fluid of livebirths, approximately 10 percent of all babies examined showed definite evidence of brain injury.

Furthermore, from these facts plus a general knowledge of the nature of the disease, it can reasonably be assumed that cerebral palsy may be a contributing factor in the cause of many other diseases. This, however, requires further explanation.

Usually it is not clearly understood that cerebral palsy is merely an injury similar to a cut or bruise of the finger except that in this case the injury is of the brain. The brain, however, actually extends through nerve tissue to all parts of the body. As such it is further unlike the finger injury in that the finger cut is a local condition, the affected tissues of which can, with relative ease, regenerate and heal leaving the finger unimpaired. In the case of a brain injury, however, an important nerve may be severed or bruised which extends directly to an outer extremity of the body such as to a foot or hand or indirectly to an organ of the body such as the stomach or heart. Unfortunately nature does not, or cannot, repair an injury of this type due to the complexity of the job to be done. A severed nerve usually remains severed. A heart ailment or a stomach ailment, for example, therefore, could conceivably originate as cerebral palsy, even though the nerves serving the various organs are not as subject to injury as those which control the voluntary motions. It can be seen from this discussion then that cerebral palsy may be a contributing factor in the cause of many other diseases. It can also be concluded that the disease is not hereditary for obviously an injury is not transmittable. Treatment is usually confined to one or more of the various methods of substituting another nerve to perform the tasks of the injured one.

The above figure of 10 percent would indicate that cerebral palsy is one of the most if not the most prevalent of all diseases. At first thought, this figure would appear exaggerated, for it immediately suggests the question, "Why have we not heard more about this disease?" The answer to this question is multifold.

In the first place the disease is not easily detected. While Dr. Gordon, in his thesis, does not speculate on the effects of these injuries, to anyone who has observed the great variety of ways in which the disease is manifested and the varied degree of affectation, it is reasonable to conclude that of this 10 percent a large majority of cases are affected to such a slight extent that the patients are unaware of the injury and consequently may be unaware of any possible impaired capacity throughout their entire life span. Of those patients who are aware of some impairment, the diagnosis may not be cerebral palsy but some other disease.

In the second place, information on cerebral palsy is extremely limited. It does not take much time for even the layman to exhaust the library on this subject. The reason for this is probably due to the fact that practically no extensive research has been performed in this field. Until recently there has been no effective treatment. Hence the medical profession has regarded it as an incurable disease and therefore not worth the time required to obtain what information is available or to attempt to apply it in practice. Few physicians can afford to deviate from their general practice to venture into something about which so little is known. There is no profit in a disease which through lack of research, a cure seems impossible.

Even knowing the few facts which are available to the physician, the treatment is so time-consuming that to do justice to his patient he would have to neglect other patients.

I personally know a case in which a parent took her child to a pediatrician. This specialist told the parent the child was all right, that all he needed was a pair of corrective shoes. Accordingly he wrote out a prescription. The parent took the child to the shoe store with the prescription for the shoes. The shoe salesman immediately recognized the child's condition and correctly diagnosed the case as cerebral palsy which was later verified.

My interest in cerebral palsy does not come from technical knowledge as my education in this direction is limited to a premedical course. I am primarily interested as a parent of a cerebral-palsied child. So while I am not an authority I have experienced what so many parents have experienced—wandering from doctor to doctor, consulting with specialists, therapists, and trained nurses, and finally searching the library to find a bit of information which might be of benefit to a child.

The case history of my son is typical in that it reveals the essential elements which are involved in this discussion. Briefly it is as follows:

At 2½ years of age he could not walk. At 3 he could walk with fear but did not talk. A physical and mental block was barring initiative. At this time we had consulted no less than 18 physicians, psychiatrists, and specialists. Of these only the ones who knew nothing gave us any hope. Those who did know a little about it gave us no hope at all.

Quite by accident through a small newspaper announcement we discovered that the Public Health Service had set up here one of the very few pediatric clinics in this country. Through this institution we first found the answer to our problem and the first true diagnosis of our child's affliction. We were able to arrange for a 30-minute period of occupational therapy once a week although this clinic was very much understaffed. While this was insufficient for a thorough rehabilitation it proved a godsend to us. Our child's case was slight. Most cases require daily attention.

Later we were referred to the District of Columbia Society for Crippled Children, a charitable, nonprofit organization devoted to the care and education of crippled children. At this time there were no private institutions through which we could purchase these necessary services. Even today it is still impossible for the average citizen to pay the exorbitant fees required by the few private institutions which now exist.

At the age of 3½ through the wonderful help of these two institutions our son began to talk. At 4 his vocabulary had increased immeasurably. Today, at 7, after completing the first half of the first grade in school, his progress can be said to be little short of miraculous. The other day he brought home a doll house which he had made himself under the supervision of an occupational therapist. He has operated small looms, built simple boats, and many other items. All these things now are the accomplishments of a child which was at one time declared hopeless by specialists in the neurological field.

In conclusion, I submit, that if a research foundation of the kind proposed were set up, the causes of cerebral palsy studied and means thereby of prevention and treatment developed, there would, I believe, be a reduction in many systemic diseases as well as cerebral palsy itself, a reduction in many mental diseases, and possibly a reduction in crime.

Cerebral palsy is the same nonrespecter of persons as infantile paralysis. Many a physician or professor has been confronted with a case in his or her own family. No one who marries can escape the possibility of being the parent of a cerebral-palsy child.

Mr. PRIEST. We will proceed next to a discussion of the bill specifically dealing with epilepsy. We are keeping in mind, of course, that some of these bills before us are omnibus research bills and some deal with epilepsy alone, and some with cerebral palsy, so the testimony may be given covering any or all of these subjects.

Without objection, we will insert reports from the Federal Security Agency and from the Comptroller General of the United States.

(The reports are as follows:)

FEDERAL SECURITY AGENCY,
Washington 25, May 27, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of March 31, 1949, for a report on H. R. 3893, a bill "to amend the Public Health Service Act to provide for research and investigation as to the cause, prevention, treatment, and possible cure of epilepsy."

This bill would establish a National Epilepsy Institute in the Public Health Service and would authorize the Surgeon General to conduct and promote—directly and through grants-in-aid, fellowships, traineeships, etc.—researches, investigations, public education, demonstrations, and control projects relating to the cause, prevention, and methods of diagnosis and treatment of epilepsy.

Authority for the Surgeon General to make grants for research and investigations as to the cause, prevention, and cure of epilepsy has already been provided by the National Mental Health Act (P. L. 487, 79th Cong.).

Research on the subject of this disease is included in the program of research in the Public Health Service and grants for studies on epilepsy have been made already by the Surgeon General upon recommendation of the National Mental Health Council. Since epilepsy is a neurological disorder it will be included in the research in this field now being carried on through the National Institute of Mental Health, which will investigate the whole group of diseases affecting the spinal cord on a more extensive scale when the Clinical Research Center at Bethesda is completed.

Individuals are now being trained under the National Mental Health Act and their services will be available in the future to a large number of epileptics. Epileptics are now being treated under the community-services program already established under this act through grants to States. Also, insofar as the bill refers to epilepsy in children, it should also be noted that programs of service are currently a part of the crippled children's programs organized by the States under the grant-in-aid provisions of title V, part II, of the Social Security Act administered by the Children's Bureau of the Social Security Administration in this agency.

In view of these programs already under way or now being put into effect, we believe that the provisions of H. R. 3893 calling specifically for research on epilepsy are unnecessary and that the establishment of a separate institute for this purpose would be administratively undesirable.

The Bureau of the Budget advises that there is no objection to the submission of this report to your committee.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

GENERAL ACCOUNTING OFFICE,
Washington, April 27, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

MY DEAR MR. CHAIRMAN: Further reference is made to your letter of March 31, 1949, acknowledged by telephone April 5, requesting a report on H. R. 3893, Eighty-first Congress, entitled "A bill to amend the Public Health Service Act to provide for research and investigation as to the cause, prevention, treatment, and possible cure of epilepsy."

A companion bill, S. 659, was introduced in the Senate on January 27, 1949.

The purposes of the bill are set out in section 703 of the proposed amendment as follows:

"For the purpose of improving the health of the people of the United States through the conduct of researches, investigations, public education, and demonstrations relating to the cause, prevention, and methods of diagnosis, treatment, and restoration of those afflicted by epilepsy; assisting and fostering such researches and activities by public and private agencies, and promoting the coordination of all such researches and activities and the useful application of their results; training research workers; training undergraduate and postgraduate personnel in matters relating to epilepsy; training specialized social workers in this field; training parents of epileptic children; and developing and assisting States and other agencies in the use of the most effective methods of prevention, diagnosis, treatment, and restoration of those afflicted by epilepsy, including refresher courses for physicians, there is hereby established in the Public Health Service (hereafter referred to in this title as the 'Service') a National Epilepsy Institute (hereafter referred to in this title as the 'Institute')."

Briefly, in order to carry out the said purposes, the bill would authorize the Surgeon General of the Public Health Service, under the supervision and direction of the Federal Security Administrator, to conduct researches, etc., relating to epilepsy, cooperate with other agencies in researches, education, and control programs, make grants-in-aid to public or private agencies and to individuals for research, education, and control projects and programs, establish an information center, secure the assistance and advice of experts in the field of epilepsy, establish research fellowships and traineeships, treat voluntary patients, and, upon recommendation of the National Epilepsy Council, adopt such additional means as deemed necessary or appropriate to carry out the purposes of the legislation. Further, the bill would create a National Epilepsy Council, consisting of the Surgeon General of the Public Health Service, the chief medical officer in charge of neurology of the Veterans' Administration, the chief medical officer in charge of neurology of the Navy, the chief medical officer in charge of neurology of the Army, the Chief of the Children's Bureau, or their respective representatives, and 12 other members to be appointed without regard to the civil-service laws by the Surgeon General of the Public Health Service, each member to receive compensation at a rate to be fixed by the Federal Security Administrator, not exceeding $75 per day, while attending conferences or meetings of the Council or otherwise serving at the request of the Surgeon General of the Public Health Service. Section 705 (f) of the proposed amendment would require the Council to establish subcommittees specified therein. Section 706 (a) would authorize grants-in-aid to States, political subdivisions of States, and public and nonprofit institutions and individuals, for the establishment of programs of prevention, etc., of epilepsy, payments to States to be made by the Secretary of the Treasury upon certification by the Surgeon General of the Public Health Service prior to audit or settlement by the General Accounting Office. Section 707 would authorize the acceptance of gifts for the purposes of the act and would authorize necessary appropriations.

This office has no information as to the need or desirability of the proposed legislation and, therefore, I make no recommendation as to the merits of the bill H. R. 3893.

With respect to details of the bill, there is noted the following:

1. Apparently the word "is" should be inserted after the word "it" in line 12, page 2, of the bill.

2. It appears that the provisions of section 706 (a) of the proposed amendment, relating to grants-in-aid "to States, counties, health districts, and other political subdivisions of States, and to public and nonprofit institutions and individuals for the establishment and maintenance of programs for prevention,

treatment, and control of epilepsy," overlap to a considerable extent the provisions of section 704 (4) relating to grants-in-aid "to universities, hospitals, laboratories, and other public or private agencies and institutions, and to individuals, for research, education, and control * * * projects and programs."

3. In section 706 (a) the word "approximate" in line 20, page 9, presumably is intended to be "appropriate."

4. The language of section 704 (8) appears to be incomplete or incorrect—possibly the word "of" in line 15 on page 5 should be eliminated and a comma inserted in its place.

Pursuant to your request, two carbon copies of this report are enclosed herewith.

Sincerely yours,

LINDSAY C. WARREN,
Comptroller General of the United States.

STATEMENT OF DR. WILLIAM G. LENNOX, M. D., CHILDREN'S MEDICAL CENTER, BOSTON, MASS.

Our next witness will be Dr. William G. Lennox, M. D., Children's Medical Center, Boston Mass.

The committee will be delighted to hear your statement at this time.

Dr. LENNOX. I am Dr. William G. Lennox. I am associate professor of neurology, Harvard Medical School; president of the International League Against Epilepsy; national consultant in epilepsy to the Veterans' Administration; and chief of the seizure division, Children's Medical Center, Boston, Mass.

Disorders of the brain are outstanding in importance, because mind as well as body may be involved. Heart disease, cancer, rheumatism indeed maim or kill the person affected, but a brain-diseased person may bring disaster to many.

Half the hospital beds in this country are occupied by persons with some derangement of the nervous system. Deep study and understanding of the brain would benefit not one, but many, diseases; not thousands of persons, but millions.

For a number of reasons epilepsy is of peculiar value for study and epileptics are peculiarly in need of help. Of these many reasons, I will mention only five.

1. Epilepsy is a paroxysmal disease. One moment the epileptic is as normal as you or I, the next moment body and mind are in the wildest turmoil, a condition of abrupt and alternating health and disease made to order for the medical researcher.

2. Epilepsy is profitable for study. Immediate returns are certain. The walls are already breached. In the past 10 years expenditure of less than a million dollars has yielded new methods of diagnosis (the brain-wave machine), and new means of medical and surgical treatment. These gains have transformed the lives and prospects of many thousands of our citizens. If only one-tenth of our present epileptic population is brought from dependency to self-support, the lifetime money saving would be something like three billions of dollars.

3. Epilepsy is a common disease; well over half a million are affected, as many as the victims of active tuberculosis or diabetes or those crippled by polio and cerebral palsy. Realization of the numbers involved is obscured by the need for secrecy. Although epileptics are not accepted for military service, in the last report of

the Surgeon General, epilepsy, next to schizophrenia, was given as the most frequent cause for medical discharge from the United States Army. Since epileptics are not accepted, this can only mean that many kept their illness secret.

4. The handicap of epilepsy is as much social as physical. The child barred from school and education, the man refused employment simply because he may be subject to seizures is as handicapped as the occupant of a wheel chair. The task of stopping seizures is as nothing compared to the problem of finding and keeping a job. For thousands of years epileptics were mistreated because they were possessed of demons. The Workmen's Compensation Act and civil service are the modern equivalents of the old belief in devil possession. Most epileptics, except for seizures, are mentally and physically a cross section of the population. Most of the adults could and should be working. To support in idleness thousands of the able-bodied simply because of an occasional seizure is pure waste. But working with safety implies proper job placement, and this requires knowledge by the employer of the seizures, and knowledge, by and large, means "no job."

Consider the war-wounded epileptic veteran—can he obtain a job? In most cases, no. Who says so? A representative of the Government, the local civil-service officer. Even if the job is in a veterans' hospital under the eye of doctors and nurses, the stony answer may still be "no."

5. Plainly, epilepsy offers peculiar opportunity for savings in money and in woe. Under proper medical treatment, the great majority of epileptics can be relieved of the great majority of their seizures and oftentimes of all. I could relate scores of cases of men and women, once ill and hopeless, who are now working productively and happily. Even the fog of public ignorance and intolerance is beginning to lighten.

The requirements for further advances are as follows:

(*a*) Grants for medical research.

(*b*) Clinics for early diagnosis and treatment and for training of doctors and social workers.

(*c*) School-sanatoriums for children of adequate intelligence, unable to attend public schools.

(*d*) Reversal of certain foolish and unfair laws born in the days of ignorance.

I believe that an annual sum of $3,000,000 expended wisely would save many times that amount for this generation and for each that follows.

You, our legal representatives, have in this bill, H. R. 3893, the opportunity to save taxpayers' money and to serve the public good—now and for the far future.

Mr. PRIEST. Doctor, could you give the committee some idea of the present extent of research in epilepsy?

Dr. LENNOX. I judge there are perhaps between $100,000 and $200,000 being spent in research. The Veterans' Administration maintains a National Epilepsy Veterans' Service at Cushing Hospital with a budget of $75,000. That is the largest sum I am sure of.

Mr. PRIEST. Are there many private clinics or medical schools doing some research on this subject?

Dr. Lennox. Yes; there are a number of schools. Dr. Tracy Putnam who is here represents a school that developed dilatin, which is one of the most effective medicines for the treatment of epilepsy. There is other work going on. It cannot continue without more support.

Mr. Priest. As I stated at the beginning of the hearing, we have a number of bills calling for the establishment of institutes to deal with various diseases. We have also an omnibus research bill. I want to get your opinion as to the feasibility of the establishment, let us say, of a neurological institute with various divisions to deal with the separate diseases. Do you think that would be effective, or would it be more effective to establish a separate institute on each disease, as called for in these bills before us?

Dr. Lennox. I think that it would be logical and wise to have an over-all program. My only stipulation with regard to epilepsy is there should be some provision whereby the amount spent might be in proportion to the number affected, because the popular opinion is that epilepsy is an uncommon disease simply because it is a secret disease, whereas it is certainly more numerous than some considered in the omnibus bill.

Mr. O'Hara. Dr. Lennox, do I understand that you specialize particularly in the study and treatment of epilepsy?

Dr. Lennox. Yes. I have done nothing else for the past 28 years.

Mr. O'Hara. I am advised that you are considered probably one of the outstanding experts upon that subject in the United States, if not in the world. Would modesty prevent you from admitting that?

Dr. Lennox. I would rather say that what I do not know about epilepsy is very large.

Mr. O'Hara. Perhaps your answer illustrates the difficulty—that even the devotion of a lifetime on your part to the study of this disease indicates there is still much to be found behind the curtain of uncertainty.

Dr. Lennox. The surface has only been scratched.

Mr. O'Hara. Doctor, is epilepsy a disease with which the individual is born, or may it come by shock? The reason that I ask that question is that I notice that you are one of the consultants of the Veterans' Administration and you mentioned something with reference to the epileptic veterans. I wonder if there is an association of the war with epilepsy.

Dr. Lennox. Epilepsy may be caused first by a transmitted predisposition to seizures, probably accounting for three-fourths of the cases, and it may be caused by some injury to the brain, which has occurred since conception. One such injury is war wounds, and we estimate there will probably be 50,000 epileptic veterans of whom perhaps 15,000 will have epilepsy as a direct result of war service because of damage to the brain from gunshot wounds.

Mr. O'Hara. Epilepsy is the result of some damage, either prenatal or subsequent to birth?

Dr. Lennox. The prenatal part may be a transmitted predisposition which occurs also with many medical conditions. A person is simply born with a certain weakness, and any added injury to the brain brings it to the fore.

Mr. O'Hara. Is epilepsy hereditary?

Dr. LENNOX. Yes; there is a hereditary factor in most cases.

Mr. O'HARA. Is it true that in the course of the last 25 years there have been a number of cures made of epilepsy?

Dr. LENNOX. Yes. I would say that at the present time three-fourths of the patients can be relieved of at least three-fourths of their seizures, and many can be completely relieved. That is primarily due to new methods of study. There is this brain-wave machine by which we can diagnose and determine what part of the brain is affected, and then there is the development of new medicines of which we now have three or four that have been developed in the last 10 or 15 years.

Mr. O'HARA. Do you use shock treatments at all?

Dr. LENNOX. Not for epileptics.

Mr. O'HARA. That would have an adverse effect?

Dr. LENNOX. They have enough convulsions as it is without giving them more.

Mr. BENNETT. In your recommendations on page 3 of your statement, under "D," you say, "Reversal of certain foolish and unfair laws born in the days of ignorance" ought to be repealed. Do you have in mind any specific legislation?

Dr. LENNOX. Yes. I am sure you are surprised to know that 14 of our States prohibit the marriage of epileptics and impose very serious fines, not only for the persons marrying, but anybody who assists. The immigration laws prohibit the entrance of an eplipetic, even though he comes for medical advice. Such a person is detained at Ellis Island and has to put up a bond. Then there is the workmen's compensation law that I speak of.

Mr. BENNETT. Do you think that the immigration law should be changed in that respect?

Dr. LENNOX. It should be, of course.

Mr. BENNETT. For what reason? I do not follow your reasoning.

Dr. LENNOX. The immigration laws are made so that the person will not become a public charge, with the idea that epilepsy does permanently affect the person and that eventually he will be a public charge. A person coming in only for medical advice, expecting to stay a few days or weeks and go back again, should be allowed to come in as any visitor to this country might be.

Mr. BENNETT. The disease is not contagious?

Dr. LENNOX. No, sir.

Mr. PRIEST. Thank you very much for your appearance, Dr. Lennox. We will now hear from Dr. Arthur A. Morris.

STATEMENT OF DR. ARTHUR A. MORRIS, WASHINGTON, D. C.

Dr. MORRIS. I am Dr. Arthur A. Morris, 915 Nineteenth Street NW., Washington, D. C. At present I am a consultant in neurology and electroencephalography for the Veterans' Administration, associate chief or neurosurgery at Doctor's Hospital, Washington, D. C., and president of the Neurosurgical Society of America. I studied under an outstanding authority on epilepsy, Dr. Wilder Penfield, professor of neurology, McGill University, Montreal, and since that time I have developed both experimental and clinical researches and investigations in epilepsy.

My special development in the treatment of epilepsy is within the surgical field. After detection of abnormal areas in the brain these are removed with subsequent freedom from epilepsy in 60 to 80 percent of the cases. I have contributed original experimental data on epilepsy and have published a list of contributions in this field. By having contact with the original National Epilepsy Act (S. 659) and being acquainted with its contents, and in consideration of my present status and training I would like to go on record as being strongly in favor of the adoption of the National Epilepsy Act.

It is fortunate that the advance in the treatment of the epileptic is little beyond mere description of the attack so magnificently described in Mark 22. Concepts as to the cause of epilepsy are even less advanced than treatment. Until basic physiological research and carefully controlled investigations can be made our progress will be limited to verbose writings on trial-and-error therapy.

It requires the lifetime of a man to gain impetus in the understanding of epilepsy and unless there are facilities for expert training of young men an almost total loss is felt with the passage of this one man.

Epilepsy constitutes 10 percent of the Nation's neurological burden and costs the United States $40,000,000 annually. Economically it is not intelligent to ignore so great a burden and to continue to spend so little on ways and means to keep these patients from becoming lifetime public charges. This is a curable affliction.

One could go on and on into the reasons, economically, medically, and socially when in our times we need the United States Congress and the people of the United States to know of the problems facing us now and in the future. May I beg of you gentlemen to provide the means through which some of the epileptics of today and tomorrow may be aided and their lives made perhaps to parallel those outstanding figures in history who were also sufferers from epilepsy.

I do most heartily approve bill H. R. 3893, amending the National Health Service Act, and sincerely hope that it will receive your full support.

Now, without taking your time, gentlemen, I would like to submit an editorial published yesterday in the Annals of the Medical Society of the District of Columbia, which will contain some of the medical ideas concerning progress in epilepsy, the present-day concept of the abnormality existing in epilepsy, the way it can be approached and where the actual need lies.

Mr. Priest. It will be inserted in the record at this point.

(The editorial referred to is as follows:)

Epilepsy—A Challenge

(Editorial, Medical Annals of the District of Columbia, June 1949)

"And ofttimes it [the convulsion] hath cast him into the fire, and into the waters, to destroy him; but if thou canst do anything, have compassion on us, and help us" (Mark 9:22). The physician of today may well sympathize with the disciples who came to the Master with this case of epilepsy and who were helpless before the convulsing boy. Today this feeling of helplessness can be eradicated by a common ideal among medical men, each in his own way striving to reduce this social and medical burden to the best of his ability. The outlook which this age requires will condition and add impetus to our human endeavors. This calls for a revision of antiquated ideas and old forms of therapy.

The application of old ideas to a constantly improving status in the care of the epileptic must be supplemented by hopeful and progressive thought. If one will accept the idea that the clinical convulsion is the direct result of a disturbance in the normal brain physiology, whether the exciting factor be extracranial or not, a great forward step will be made in medical thought. Too many people have the erroneous impression that convulsions are due to constipation, bad teeth, etc. It is true that the precipitating factors are not always beneath the dura, as the ancients conceived, but they are due to an alteration of the cerebral or generalized chemical physiology to which the brain, as well as other organs demonstrates its susceptibility. Thus it is evident that at the time of the first convulsion, whether it be in infancy or adulthood, a proper appraisal of precipitating factors as well as causes should be made. By so doing one may avoid the tragedy of a lack of understanding and discover causes which may be remedied at an earlier date but which later may prove difficult to control. Ideas based on the belief that recurrent convulsions are due to "demons, trivial head injury, cosmic influences, emotional possessions, bad teeth, septic tonsils, nasal polypi, refractive errors, phimosis, intestinal worms," etc., do not account for the tendency to convulsions.

Pessimism must be replaced by optimism in the treatment of recurrent convulsive seizures. That there is reason for optimism is shown by a comparative analysis of the progress in the development of anticonvulsant drugs. A patient who had 20 attacks per month without medication will have 10 on bromide, 7 on phenobarbital, and 2 or less on dilantin. Sixty-five percent of selected persons with focal epilepsy, uncontrolled by medication, can be cured by surgical cortical resection. This comparatively recent addition to the epilepsy armamentarium has been proven most effective and provides for increased optimism.

The aim in medical or surgical treatment of epilepsy today is directed toward two goals: (1) elimination of clinical seizures, and (2) the establishment of normal cerebral neurophysiology. Unless the latter point is given due consideration the seizure habit will perpetuate itself and produce deleterious effects on the higher functional cerebral processes such as memory, thinking, and abstract thought. A patient whose seizures are eliminated by medication and whose electrical neurophysiology (electroencephalogram) is rendered normal has a far superior therapeutic result than the patient who is free from convulsions but who continues to have subclinical physiologic manifestations. A person may have numerous subclinical electrical seizures and be entirely free from clinical attacks and yet deteriorate mentally. The subclinical seizures may cause atrophy. Cortical atrophy increases the likelihood of clinical seizures prior to the climateric, and thus a vicious cycle is established.

The seizure habit is the lethal epitome of normal cerebray function whether it be at the clinical or subclinical level. Thus, the ideal time to initiate treatment in the epileptic patient is during the phase of relative clinical quiescence and not during a period burdened with frequent attacks, since the fighting chance is in the former phase. The fact that many unexplained symptoms, such as dizziness, syncope, abdominal pain, headache, and behavior disorders when directly related to the epileptic-like abnormal neurophysiology, are subsequently eliminated by anticonvulsant drugs is evidence that a malfunctioning brain can cause almost any type of somatic complaint. The epileptic who is free of convulsions and yet persists in having syncope is demonstrating the failure to establish normal brain function.

Patients with convulsive disorders constitute approximately 10 percent of the Nation's neurologic burden. Thus, from a purely economic viewpoint this problem can no longer be neglected. Through the united and sustained efforts of the neurosurgeon, neurologist, psychiatrist and all physicians this challenge can be met. Assisted by new drugs, highly developed surgical technics, electroencephalography and other specialized procedures, epilepsy can be conquered. The superstition, fear, and despair of the past will be overcome.

Mr. Priest. Is there any special clinical work being done in the District of Columbia? That is where you practice, I believe.

Dr. Morris. Yes.

Mr. Priest. Is there any special clinical work being done here in this field in the District?

Dr. Morris. Yes. The organization is somewhat embryonic at the moment, but there are epileptic clinics at the Georgetown University Hospital and there is special time devoted to it in the neurological clinic in the George Washington University Hospital. There also is some time given at the Gallinger Hospital for the benefit of charity patients, and there is some time given at several other hospitals in the neurological service for the express treatment of epilepsy. At Doctors' Hospital and in my own private clinic we carry on considerable control for that sort of factor.

Mr. O'Hara. Dr. Morris, I assume that one of the handicaps that the epileptic has is the psychological fact that he feels he has been handicapped in the ordinary pursuits of an individual. Of course, that limits him in his employment and in his endeavors.

Dr. Morris. Right; that is true.

Mr. O'Hara. So when a substantial cure is made of a patient who has been afflicted with epilepsy, there is a psychological effect upon that patient?

Dr. Morris. That is true.

Mr. O'Hara. So anything that may be done in the way of contributing to the study and the research and recovery of these people is of tremendous benefit, not only to the individual but to the economic resources of the country as well; is that not true?

Dr. Morris. Very true, economically and socially, to the community in which these people live and to the family. Many times members of the family will not marry because they know of a distant relative who has had epilepsy. Those concepts should be handled not just with the patient but with the other people as well.

Mr. O'Hara. Is there a percentage of heredity quite prevalent in epilepsy?

Dr. Morris. I think the term "predisposition to seizures" is better than calling it hereditary. The incidence of epilepsy, or the incidence of family history of epilepsy, among persons who have epilepsy themselves is between 2 and 4 percent, depending upon the specific type of seizures encountered. The main thing is to determine what the patient has. A patient is an individual problem, like you sitting in that chair. You are not like any of us here, although you have resemblance to us. You function separately and your problem is individual. That is the big crux of the situation.

Mr. O'Hara. Each case has to be treated individually?

Dr. Morris. You cannot treat 100 epileptics here and 100 epileptics there with the same therapy and expect their course to be parallel. It will not be alike in any shape, form, or manner. I wish it were true.

Mr. Priest. We thank you very much, Dr. Morris.

We will now hear from Dr. Tracy J. Putnam.

We are glad to have you again before the committee, Doctor.

STATEMENT OF DR. TRACY J. PUTNAM—Resumed

Dr. Putnam. I am appearing today because I happen to be a member of the National Academy of Cerebral Palsy and a member and past president of the American League Against Epilepsy, and a member of the advisory board of the Laymen's League, and a member of the Medical Advisory Board and past president of the National Association to Control Epilepsy.

I come not because I can add much to what has already been said about these two diseases. You have heard from a great expert in epilepsy, my old friend Dr. Lennox. I would feel that the distressing problems of cerebral palsy have not been adequately aired this morning. I feel quite sure that the depositions that will go into the record will show what a harrowing condition this is.

I am here to point out that all three of these conditions, which taken together account for something like 1 or 2 million patients in this country, have certain points in common and I believe they can and should be attacked jointly. I believe that a flexible attack on these and other neurological conditions, which perhaps affect another 1,000,000 people, would be thoroughly worth while to this country.

There are certain limitations and additions that I would like to make regarding that statement.

In the first place, I would like to quote what our old professor of neurology told us when we were medical students and he was defining the subject. He said, "This is a specialty which cares for all the distressing cases that the other specialties cannot bother with."

The brief, intensive course in neurology that you gentlemen have had in the past few days will convince you that this is indeed the truth. There are some other distressing conditions, not as prevalent, but quite as distressing as those we have heard reviewed which would also benefit from a foundation devoted to neurology. The major part of my professional life has been spent in the study of diseases of this kind. Despite a good many disappointments and set-backs, I feel it has been well spent.

I believe that funds for the study of these diseases would represent a real economy in the long run. I might point, for example, to the discovery of the new series of drugs to control seizures which were carried out in my laboratory at the expense of perhaps $1,000 or $2,000. I should estimate that these drugs have saved several millions of dollars, since they have helped people to be relieved from seizures and permitted them to live a normal life again.

I think that a person suffering from certain forms of cerebral palsy who, as the result of an operation, is returned to productive life, means a saving of many thousands of dollars to his family and the public.

In my experience in neurological research, and from the experience of my friends who have been similarly occupied, obtaining sufficient funds for investigative work is the limiting factor. In each of these conditions I know of certain lines of investigation which I feel sure could be profitably followed, and they are not being followed because nowhere can the funds be found.

All the departments of neurology with which I am acquainted have had their budgets cut down rather than expanded since the war. We are facing a real emergency in medical research in general and in neurological research in particular. Neurological research is in a peculiar position because neurology is usually regarded as a minor specialty which deals with rare and mysterious diseases. How rare they are I think you can see from the facts which have been presented these 2 days. Taken in the aggregate they are not rare. They are not as mysterious as we thought they were because we have recently learned methods of studying them and have learned efficient methods of treatment for some of them.

It has been my experience that when funds are entrusted to well-meaning internists and psychiatrists they do not get expended for neurological research.

I wish to express myself as heartily in favor of an omnibus bill which will have provisions for each of these conditions and perhaps a few other miscellaneous ones, but which will be so set up that the funds will be devoted to diseases, as Dr. Lennox has suggested, more or less in the order of their prevalence, although I think it would be a pity if the bill were so rigidly drawn that a promising lead which might bring about the solution of some less common problem should be overlooked.

Mr. O'HARA. In the matter of these people suffering from cerebral palsy or epilepsy, does the patient himself usually know the approaching symptoms of an attack or seizure?

Dr. PUTNAM. The patients with epilepsy may or may not know when a seizure is imminent or impending. It would be difficult to say how often the patient has forewarning. Perhaps in half the cases. As to patients suffering from cerebral palsy, they suffer from it all the time, and they really suffer. Some of them really suffer real torment.

Mr. O'HARA. While you testified in behalf of these bills with reference to these specific diseases, is it understood that you are in any way speaking for or against the so-called national health bill?

Dr. PUTNAM. I am speaking for them in general, but I hope that they will be set up in such a way that these distressing neurological conditions will receive their full share of attention.

Mr. O'HARA. I am speaking of title VII of the omnibus bill. Are you making any comments with reference to that section of the bill?

Dr. PUTMAN. No.

Mr. O'HARA. Compulsory health insurance?

Dr. PUTMAN. I am not sufficiently familiar with the provisions of that section to feel that I can comment on it at this time.

Mr. O'HARA. Your remarks were directed solely to these specific bills about which you have testified?

Dr. PUTMAN. That is correct. I am pleading primarily for aid in the investigation of neurological diseases.

Mr. BENNETT. Doctor, one of the big problems that confronts those of us who are being called upon to enact legislation on this subject is not the necessity for it—I think that everybody agrees that more work should be done in research and that the Federal Government should provide some additional funds to augment the funds now being spent by private individuals—but in your testimony you mentioned one thing about which you are concerned, and that is your fear in connection with any Federal funds appropriated for epilepsy and cerebral palsy you may not be allocated your share of those funds. Is that a fair statement of your position?

Dr. PUTMAN. Yes. I think there is a real problem as to how these funds should be allocated or divided among the various disorders to which they apply.

Mr. BENNETT. Under the bills before us, as I understand them, the expenditure, and division of Federal funds for research is left to the discretion of the Surgeon General. He may set up an institute and spend the entire amount appropriated within his own agency, or he may provide a certain part of it for grants to any number of private institutions, or he may provide money for scholarships, or he may provide money for scholarships within the Federal set-up.

Have you given that matter any thought—whether any law that is passed here ought to contain some limitations on the discretion of the Surgeon General as to how the funds should be spent; in other words, do you think it is wise to leave it to his discretion whether the entire amount should be spent within his agency, or whether he should be required, for example, to allocate a certain part of it, or a certain percentage of it, to various private groups for these special purposes?

Dr. PUTMAN. I believe that some limitation should be put upon his discretion in that respect. It has been my experience that the most imaginative and constructive work has usually been done by individuals who have had bright ideas and may be working anywhere in the country. My own preference would be to see the majority of the funds applied in that direction, with a certain amount allocated for fellowships. We are running short of well-trained young men to carry these studies on. The economic situation is such that it is very difficult for a young man to embark on a career of medical research now, much more difficult that it used to be.

Mr. PRIEST. On that subject I think that it might be interesting for the record—and this is not in any way to be controversial with my good friend from Michigan—to point out that on the basis of appropriations of last year the National Institutes of Health, over-all, allocated 51.8 percent to work outside of the Institutes.

In the field of cancer, 70 percent of all the funds were allocated for work in connection with institutions throughout the country and only 30 percent for the operations within the Institutes itself, and in heart, 73.6 percent was allocated to research outside of the Institutes; in dental work, 51.8 percent, and in mental health, 78.8 percent, indicating that more than 50 percent in each category was allocated outside the Institutes.

I thought that those figures might be interesting in the record at this point. That will come under the plan of allocation by the Surgeon General after conferences with the advisory councils in each institute.

Mr. BENNETT. The advisory council is appointed by the Federal Security Administrator, I think. I want to make the record clear, Mr. Chairman, I am not criticizing the Surgeon General for what has been done. My concern is this: In the legislation we are now considering, we are largely expanding the powers of the Surgeon General and vastly increasing this program. My point is that it would do no harm to limit the power of the Surgeon General; in other words, require in the future that he do the things that he did last year, because next year he might not do it. Another Surgeon General might not do the same thing.

Mr. O'HARA. I share with you your concern in the treatment of these neurological diseases, and that proper application be made of the funds. I am a little fearful, as you are, whether the Surgeon General, or the one who allocates the money, is going to allocate it to those who should be given the consideration. Do you share that concern?

Dr. PUTNAM. I do. Someone has to decide, and I suppose there will always be a fringe of uncertainty as to where the individual's prejudice might be deleterious. I feel that it is better to run that chance than to do without the funds.

Mr. O'HARA. There is certainly a group who are interested in this field.

Dr. PUTNAM. Indeed there is.

Mr. O'Hara. And they should be considered in the matter of the disposition of the fund.

Dr. Putnam. That would seem reasonable to me.

Mr. Priest. It will be necessary for the committee to adjourn at this time. We will reconvene at 2 o'clock this afternoon in an endeavor to finish our schedule of witnesses today. We will appreciate the cooperation of everybody concerned.

The committee will stand adjourned until 2 o'clock.

(Whereupon, at 11:20 a. m., the committee adjourned to reconvene at 2 p. m.)

AFTER RECESS

Mr. Priest. The committee will come to order.

When the committee recessed this morning, Dr. Putnam had finished his testimony, and the Chair was notified at the time that Mr. Strachan desired to make a brief statement on the industrial effect of epileptic unemployed.

We will be very happy to have that statement at this time, and then proceed with the consideration of leprosy.

STATEMENT OF PAUL A. STRACHAN, PRESIDENT, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, WASHINGTON, D. C.—Resumed

Mr. Strachan. Mr. Chairman, I wish to address myself on the subject of epilepsy to the section of the proposed bill wherein we state that among other things, we wish to establish an information center and research on prevention, diagnosis, and treatment, to collect and make available through publications and other appropriate means research and other activities carried on pursuant to that title.

Now, that same section is in a great many of the pending medical research bills. I have had a great deal of experience, in fact, I am the author of an act which most of you present voted for, National Employ the Physically Handicapped Week. I bring that in because the end of all of this legislation logically should be to make it more feasible for disabled people to earn a living, to get off the relief rolls, and start paying taxes. That has always been the objective of the program which our federation advocated.

This section which I just read is a tremendously important one. It is for this reason: No private organization in this country can sell the handicapped as potential employees. I insist on that. Veterans' organizations have tried it. Professional organizations have tried it. Physicians and others have tried it. But individually they have failed.

This thing, Mr. Chairman, is so great that the only way it can possibly be successful is under the handling of government, and I say "big government," but we must bring into that orbit collaboration and cooperation with governmental agencies that are interested, public and private.

No single group in this country is big enough to deal with this handicapped problem except government.

A few months ago in addressing groups in associated industries in New England, I pointed out to them that we could not take the

28,000,000 handicapped and say to the Chamber of Commerce or to the National Association of Manufacturers or to veterans or to labor or any other organization, "Here, you rehabilitate these people." Nobody has money enough or time enough, and to be frank there are not the trained people nor facilities to do the job. We have made a small start on employment of handicapped and if the committee will pardon me, I still think it is relevant to the general subject, I should like to tell the committee some good news on that subject.

National Employ the Physically Handicapped Week has been on the books since you gentlemen kindly put it there 5 years ago, and if I were capable, I should like to pat every Member of Congress on the back for that, because here is what you did. I had the Bureau of Labor Statistics make an estimate of the amount of money which had been received in salaries or wages by handicapped people who had been placed by operations of that act. I say that this should please you immensely. Not counting this year, more than $500,000,000 has been paid out to these people in salaries and wages, and $100,000,000 has been paid by the handicapped to the Federal, State, and municipal governments as taxes. That is a splendid thing for Congress to have done, and I want to thank all of you for the support that you have given the "Week," and, gentlemen, I am going to ask you to give it more support, because it is just beginning to dawn upon the American public that this is not a charity proposition, but an economic one. If we spend $5,000,000,000 to get our handicapped people on their feet, as many as it may be possible to rehabilitate, the country would be the beneficiary. I am not going to debate here today any pending program, but rather I want to emphasize that this is an economic proposition, and let us take whatever steps are reasonable and possible to get these people to work.

I wish to dwell for a moment upon the difficulties of epileptics in employment. The records of the Federal Government at the time the War Manpower Commission was operating, showed a tremendous difficulty in placement of the epileptics, and I, myself, wrote several thousand of our leading industries and made inquiry on the subject. Of course, the feeling there is that this person is unreliable, not consciously, but unconsciously, and they cannot therefore be trusted with some kinds of employment. But I have seen demonstrated already the splendid work that Dr. Lennox and others in his field have done or are doing, and as a practical man, I can assure you that the money that has been asked for by him would be the cheapest and the best investment that this Congress could ever make. I know I am right.

I want to say that the Federal Employment Service now has not been able to work out any satisfactory program to place epileptics or others of these severely disabled type groups. I am going to ask all of you to remember that according to our best statistics there are 7,000,000 in this country in the category of the totally and permanently disabled and nonfeasible for rehabilitation.

I hope that the committee will recognize, therefore, the necessity of having a real information bureau to tell the public the real facts about these people. We have made this much progress. A few years ago I demanded that the Federal agencies, Civil Service Commission, for example, at the out-break of the war had approximately 6,800 different kinds of jobs, and of that number they only admitted handicapped people to examination in some 365 of them. I knew that was wrong. I stated to the Commission, "Gentlemen, under your rules Thomas Edison could not be employed because, forsooth! he could not hear a watch tick at 15 feet, and for the same reason John Milton could not get a job teaching in an Indian school because he could not see, and Beethoven could not teach music because he could not hear. Your system is obsolete and it is ridiculous."

The segment of our population of handicapped people has grown and swelled; today we have a minimum of 28,000,000 in some degree handicapped and from other sources it is said as many as 55,000,000. I have been trying to get the Congress to pass a Census of Handicapped Act so as to include it in our 1950 census, and you here in this committee and other committees of the Congress that are preparing to spend the equivalent of hundreds of millions of dollars in this field, and we don't know where we are going. we don't know, and if we are not careful, we will be shooting in the dark entirely.

The first thing we should do is get some practical knowledge under foot. How many handicapped are there? Where are they? Of what type of disability? That does not mean that we are going to say Mrs. Smith or Mr. Jones is disabled, but we can at least lump that so we know what we are dealing with.

I am still hopeful of action by the Congress on our census-of-handicapped bill; and if such a measure comes before you, I hope you will give it your most careful attention, because it certainly is justified. I am going to ask that the committee give final consideration at the time of the drafting to the necessity of this information set-up, because we have to sell the employers of this country and the public on what these people can do. In this epileptic field, for example, there are many jobs that an epileptic can fill without any chance of failure, but the public does not know it, and employers don't know it, and, as I said, there is no agency except Government that is big enough, that has the talent and means to put out that kind of a story.

So please give proper consideration and weight.

Are there any questions?

Mr. PRIEST. I believe there are no questions at this time. Thank you, Mr. Strachan.

Mr. STRACHAN. Thank you.

Mr. PRIEST. Our next witness, and on a different subject, will be Dr. Robert Stolar.

The sponsor of the bill dealing with medical research in leprosy is Mr. Peterson of Florida, who introduced earlier in the year a bill H. R. 4030, and has introduced a new bill more recently, and that is H. R. 5234. Mr. Peterson has notified the committee that he will not be able to be present today, but he does desire to file a statement with the committee, and, without objection, his statement will be included in the record at this point, after the reports of the Federal Security Agency and the Veterans' Administration.

(The report and statement are as follows:)

FEDERAL SECURITY AGENCY,
Washington, June 16, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This is in reply to your letter of April 5, 1949, requesting a report on H. R. 4030, a bill to amend the Public Health Service Act to improve the leprosy situation in the United States, and for other purposes."

This bill is comprehensive in scope, including under nine titles detailed provisions for the dissemination of pertinent facts concerning leprosy, the medical treatment and rehabilitation and reemployment of leprosy patients, financial assistance to patients and their dependents, compensation for disability incident to leprosy, and expansion of leprosy research. Responsibility for administration of the various titles is entrusted generally to the Surgeon General of the Public Health Service, acting with the advice of a National Advisory Council on Leprosy.

This agency is sympathetic with the basic objectives of H. R. 4030, and we commend particularly the provisions directed toward "aiding and fostering a spirit of tolerance and understanding upon the part of the public * * * as an initial step in the national fight against this disease."

For almost 50 years the Public Health Service has been concerned with the problem of leprosy, and for more than 25 years it has been actively carrying on a campaign for the control of the disease in the United States. Within the past 6 years, at the Marine Hospital, Carville, La., the medical staff of the Public Health Service, by showing the effectiveness of the sulfones, such as promin, has developed the most important advance in the treatment of leprosy that has been made during recorded history.

As a general comment, we are disposed to believe, in the light of our experience that the objectives of titles I, II, and VII of H. R. 4030 can be more effectively achieved through intensification of activities already authorized by law in the field of leprosy treatment and research. The Public Health Service has definite plans for the control and eradication of leprosy in the United States. Although we were unsuccessful in securing funds in 1950 in connection with the Communicable Disease Center program at Atlanta, Ga., it is hoped that funds will be made available for the fiscal year 1951 for the purpose of conducting a pilot study in one of the endemic areas. Even though funds were not obtained, we are proceeding with an epidemiological study and some case finding under existing authority of the Public Health Service Act.

Also, we believe that general extension of our vocational rehabilitation, public assistance, and social insurance programs along lines already recommended by this Agency, would be a better approach to accomplishing the purposes of titles IV, V, and VI of the bill.

More detailed comment on the various titles of the bill follows.

TITLE I—DISSEMINATION OF PERTINENT FACTS CONCERNING LEPROSY

We believe that the present authority of the Surgeon General of the Public Health Service under various sections of the Public Health Service Act, particularly sections 301, 311, 313, 314 (c), and 315 of that act, is adequate to support an informational program such as that contemplated by this title of H. R. 4030, and hence that the provisions of title I would be for the most part duplicatory or declaratory of present law and policy.

As regards section 101 (d) of the bill, it is the deliberate policy of the Public Health Service not to use the word "leper" with regard to a patient; however, we question the feasibility of thus prohibiting the use of the word by law.

TITLE II—TREATMENT OF LEPROSY PATIENTS

This title would greatly extend the existing responsibilities and duties of the Public Health Service in the matter of providing medical care to persons afflicted with leprosy. Under present law the Service is authorized to provide medical care and hospitalization to persons requesting the same, but in Service hospitals only. Title II of H. R. 4030 would authorize and direct the Public Health Service to arrange for the furnishing of medical care and hospitalization to persons afflicted with leprosy in hospitals of the Veterans Administration, State, county, and city hospitals, other hospitals and treatment centers, and in the homes of the patients. The expense of all such care would be borne by the Federal Government, and the Public Health Service would be expected to supervise all treatment and care thus afforded.

The nature and extent of the responsibility which the Federal Government should assume in the care of persons afflicted with leprosy is a policy issue upon which opinion may differ. New knowledge of this disease seems to weaken, rather than strengthen, the case for singling out it and its victims for such special consideration as H. R. 4030 would provide. But whatever the decision on this issue, the bill seems defective in attempting to divide responsibility for the treatment and care of patients not hospitalized in Service hospitals, between the Public Health Service and the various Federal, State, and local governmental agencies which now have full responsibility. Patients are, for example, to be hospitalized in State, county, and city hospitals, but the Public Health Service is to "supply printed instructions covering the use of such (medical) treatment" (sec. 201 (b)), to "establish * * * regulations governing treatment of leprosy patients at leprosy-treatment centers, at other hospitals, as out-patients treated at such centers and hospitals, or as home patients" (sec. 202 (d), and to arrange with, and determine the qualifications of, individual physicians furnishing treatment (sec. 205)). We do not believe that such a division of responsibility is practical or conducive to the best care of the patients concerned. In the case of any individual patient, either the Public Health Service should assume full responsibility for his treatment or care at the request of the individual and the Government agency involved, or the State or local health agencies should assume that responsibility with the Public Health Service making grants to those agencies to help meet the expense of such care, and making available such expert advice, consultative services, and similar aids as these agencies may request.

The same division of responsibility appears in provisions of the bill for the treatment and care of veteran patients in Veterans' Administration hospitals, and is open to the same criticism. So long as the veterans remain patients of the Veterans' Administration, the role of the Public Health Service should be to cooperate and advise with the Veterans' Administration in like manner as it cooperates and advises with State and local agencies, on developing and using methods for the most enlightened care and treatment of persons afflicted with leprosy for whom such agencies are responsible.

Authority already exists under the Public Health Service Act to make grants to State health agencies for the control of leprosy, as of other diseases which present public-health problems, and to give technical guidance and assistance to such agencies in the control of this disease. Likewise, the Public Health Service could under existing authority make similar consultative services available to the Veterans' Administration. Finally, as already pointed out, there is authority under the Public Health Service Act to receive and treat in Service hospitals persons afflicted with leprosy who request such treatment or who are consigned there by responsible Federal and State authorities. Inasmuch as the Federal Government could not, without the full assent and cooperation of State and local governments, assume full control of the treatment of all persons afflicted with leprosy, serious consideration should be given to perfecting and more fully implementing these existing authorizations as an alternative to the approach contemplated in title II of H. R. 4030.

Certain specific provisions of title II raise other questions which might be noted here without extensive comment.

Thus sections 206 and 209 do not meet squarely the problems of forced detention of leprosy patients. Section 901 would repeal sections 331 and 332 of the Public Health Service Act which now authorize the Service (1) to receive persons afflicted with leprosy who present themselves for care or who are consigned to its care by State health authorities, and (2) to provide by regulation for the apprehension, detention, and release of persons under treatment. Section 902 of the bill might even have the effect of removing persons afflicted with leprosy from the general quarantine provisions of the Public Health Service Act, which authorize the detention, under prescribed conditions, of persons who are infected with communicable diseases in a communicable stage and who may be moving or about to move across State lines. While enforced detention has played no part in the present leprosy program of the Public Health Service (all admissions of patients at Carville being accompanied by the written consent of the patients), comprehensive legislation on this subject should preferably meet squarely, and settle, the matter of authority for forced detention. The existing authority of the Public Health Service in this respect should not be repealed or cast in doubt without careful consideration and provision for alternative methods of meeting the problem, should need arise.

Section 208 of the bill permits persons who cannot be satisfactorily treated except at Public Health Service hospitals to elect which hospital they will attend, and the same section requires that patients having a communicable type of disease who reside in a nonendemic State be sent to a Service hospital in a nonendemic State for treatment. This provision is considered unsound and unworkable. Determination as to where such patients shall receive treatment must rest with the Public Health Service, both in the best interests of the patient himself, and because staffing considerations and the availability of appropriate facilities are of major concern.

Section 321 of the present Public Health Service Act authorizes the Surgeon General, with the approval of the President, to select sites for and to establish additional hospitals and stations as are in his judgment needed for carrying out the functions of the Service. Section 214 of the bill would therefore add nothing to the authority which now exists, but would lodge the discretion in the Administrator instead of the Surgeon General and limit its exercise as to leprosy-treatment centers.

In regard to the treatment center provided for in section 215 of the bill, the sum of $1,500,000 is authorized to be appropriated. Since the present construction rate runs between $15,000, and $20,000 per bed, the afore-mentioned amount seems inadequate for a center with a capacity of 200 patients.

Section 214 of the bill also departs from the present pattern and terminology of the Public Health Service Act in specifying that treatment centers shall be known as "United States marine hospitals." The term "Marine Hospital" was eliminated from the legislation relating to the Service when the Public Health Service Act was passed. Also the provisions with respect to the treatment of narcotic addicts, and with respect to the treatment of persons afflicted with leprosy, were modified to provide for the treatment of such persons in any hospital suitably equipped for the purpose instead of being limited to certain specific institutions. We believe that any new legislation should be consistent in these respects with the present act.

TITLE III—THE NATIONAL ADVISORY COUNCIL ON LEPROSY

We question the necessity or desirability of such a statutory council, since the Surgeon General already has an Advisory Committee on Leprosy in the United States which has functioned satisfactorily for the past 3 years. If such a council is established, the number of nonmedical members should preferably equal the number of professional members, and certainly the nonmedical members should be permitted to vote on all matters considered by the Council whether medical, technical, or otherwise. Also the $75 maximum per diem provided for members of this Council is inconsistent with the $50 maximum per diem allowable to members of comparable councils of the Service.

TITLE IV—REHABILITATION AND REEMPLOYMENT OF LEPROSY PATIENTS

This title would establish a complete and separate rehabilitation and employment program for leprosy patients, the program to be administered by the Public Health Service.

The Vocational Rehabilitation Act Amendments of 1943 (Public Law 113, 78th Cong.) now make available to eligible disabled persons, which includes persons afflicted with leprosy, "any services necessary to render a disabled individual fit to engage in remunerative occupation." In other words, the present Federal-State vocational rehabilitation program, which operates in all 48 States, the District of Columbia and the Territories of Hawaii and Puerto Rico, now authorizes such educational, rehabilitation, and employment services as are contained in the proposed legislation, H. R. 4030. To establish an identical and separate program to extend already authorized rehabilitation services to a specific disability group under the Surgeon General would, in our opinion, result in an unnecessary expenditure of public funds as well as a duplication of program activities.

We question the wisdom of section 403 of the bill giving employable discharged leprosy patients a preference in filling vacancies at Service hospitals. Selective recruitment of applicants who have had a communicable disease such as leprosy together with the established scientific fact that this disease may insidiously become reactivated is not compatible with the care of patients who are ill and therefore known to have a lower physical resistance. Normally, employees caring for ill patients are selected from a healthy group and physical examinations together with past medical history are a requirement.

TITLES V AND VI—FINANCIAL ASSISTANCE AND DISABILITY COMPENSATION TO PATIENTS, AND FAMILY ALLOWANCES TO THEIR DEPENDENTS

Sections 501 and 502 of title V provide for the establishment of a public welfare fund. Certain hospitalized patients who do not have an income of $10 per month would receive from this fund the sum of $10 per month for incidental expenses while undergoing treatment at the National Leprosarium and other leprosy treatment centers. The bill does not further specify procedures for disbursement. Apparently this fund would be administered by the Surgeon General.

Title V also provides for monthly family allowances to dependents of patients who are hospitalized for leprosy treatment or who are authorized to take treatment outside of Public Health Service hospitals. Application would be initiated by the patient, certified as to correctness by the medical officer or physician responsible for treatment, and forwarded to the Surgeon General who, on approval, would forward applications to the Bureau of Public Assistance, Federal Security Agency, for payment. The bill prescribes the rate of payment for various dependents.

Title VI provides for compensation to individuals for disability incident to leprosy. Prior to discharge of a leprosy patient from treatment requirements, a determination of the degree of physical disability would be made by the medical board or physician responsible for treatment. The Surgeon General would review these findings and recommendations and, on his approval, they would be certified and forwarded to the Bureau of Public Assistance for payment in accordance with prescribed rates based on the percentage for physical disability.

Under titles V and VI the programs of family allowances to dependents and of compensation for disability are based on the existence of a specific disease. We question the advisability of singling out members of this group and their dependents to receive Federal help solely on the grounds that they have leprosy. The problem could be met far more effectively and equitably if Congress were to broaden the present old-age and survivors insurance program to provide benefits for permanent disability as recently recommended by the Administration, and the Senate Advisory Committee on Social Security. Also, at the present time, programs of assistance to needy people are available through the State and local welfare departments, some with Federal help under the Social Security Act, and others solely from State and local agency funds. Through the Federal categories of old-age assistance, aid to the blind, and aid to dependent children, some Federal funds are now available to the States to assist them in meeting the needs of many persons who would be covered under the family allowances plan proposed by this bill. Here again, the problem could be met more effectively by providing for Federal participation in the costs of assistance provided by States and localities to any needy person whether or not included in the three categories to which Federal participation is presently limited.

The allowances provided in title V for various dependents are, with few exceptions, similar to those paid under the wartime program of family allowances to dependents of men serving in the armed forces. Even during the war these amounts were not sufficient to support families, at least in urban areas, and with the sharp increase in the cost of living, these amounts are not likely to provide even minimum support for needy persons. This would mean that some of the already established forms of public assistance would have to be provided to supplement the allowances provided in title V. This would be confusing to the recipient and complex in administration.

Under the terms of titles V and VI, responsibility for making determinations of need and extent of disability is placed in the Public Health Service, and the Bureau of Public Assistance is given the role of fiscal or disbursement agent. It would be preferable to vest all such authority for determinations and payments of family allowances and disability compensation in the Federal Security Administrator, who could then work out effective procedures using the Public Health Service, the Bureau of Employees Compensation, the Bureau of Public Assistance, and other units of the Agency in a manner best adapted to their experience, facilities, and staff.

TITLE VII—EXPANSION OF LEPROSY RESEARCH

This title duplicates research authority already vested in the Surgeon General under section 301 of the Public Health Service Act, and for that reason seems unnecessary.

TITLE VIII—MISCELLANEOUS

No good purpose seems to be served by section 802 of the bill making it mandatory that the Surgeon General bring to the attention of patients undergoing treatment all laws passed by Congress and regulations established by the Public Health Service pertaining to the care, treatment, rehabilitation, and reemployment of leprosy patients. Ample authority to accomplish the objectives of this section already exists. The Public Health Service is now providing an information booklet to each patient going to the National Leprosarium at Carville informing him of his status, the facilities for treatment, and regarding the community life of which he will become a part.

TITLE IX—AMENDMENTS

Sections 901 and 902 have already been criticized (see comment on title II) as repealing or weakening the authority of the Surgeon General under sections 331, 332, and 361 of the Public Health Service Act.

Time has not permitted us to obtain advice from the Bureau of the Budget as to the relationship of this bill to the program of the President.

Sincerely yours,

J. Donald Kingsley, *Acting Administrator.*

Veterans' Administration,
Washington, D. C., June 21, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

Dear Mr. Crosser: This has further reference to your letter of April 5, 1949, requesting a report on H. R. 4030, Eighty-first Congress, A bill to amend the Public Health Service Act to improve the leprosy situation in the United States, and for other purposes.

The purpose of this bill is (1) to promote the dissemination of information concerning the disease of leprosy; (2) to provide suitable methods and facilities for the treatment of leprosy and to encourage persons afflicted with leprosy to accept proper treatment therefor; (3) to create a National Advisory Council on Leprosy: (4) to provide for the rehabilitation and reemployment of leprosy patients; (5) to provide financial assistance for leprosy patients and their dependents by means of monthly allowances; (6) to provide compensation up to $150 per month for disability incident to leprosy, and (7) to provide for expansion of research, experiments, demonstrations, and studies relating to the cause, method of transmitting, treatment, prevention, control, and elimination of leprosy. The program contemplated by the bill would be administered largely by the Surgeon General of the Public Health Service and the Federal Security Administrator with advice and consultation of members of the proposed National Advisory Council on Leprosy. Necessary appropriations would be authorized.

Operations of the Veterans' Administration would not be affected by the proposed legislation except that sections 202 and 203 of the bill would authorize and direct the Surgeon General, under certain specified conditions, to arrange for the admission and treatment in Veterans' Administration hospitals (including out-patient treatment) of veterans afflicted with leprosy. Also, section 202 (e) would authorize and direct the Surgeon General to "utilize the services and facilities of any executive department or agency of the Federal Government, as needed to carry out the provisions of this act, in accordance with an agreement with the head thereof." The proposal as a whole is of primary concern to the Surgeon General of the Public Health Service and the Federal Security Administrator from whom, it is assumed, comments have been or will be requested.

Existing procedure of the Veterans' Administration provides for the transfer of veteran leprosy patients to the National Leprosarium, Carville, La., upon confirmation of the diagnosis of leprosy by the Public Health Service. With reference to treatment in Veterans' Administration hospitals of certain types of veteran leprosy patients, as proposed in section 203 of the bill, it is noted that section 213 of the bill would appear to place complete supervision and control of the leprosy-treatment methods and policies in the Public Health Service even though the patient should be receiving treatment by the Veterans' Administration. This might prove to be impracticable, as the professional staff of the hospital in which treatments are given for any disease are normally expected to exercise supervision and control over the treatment methods employed.

Even though the Veterans' Administration will not be charged with any duty or responsibility in administering titles IV, V, and VI of the bill, which relate to rehabilitation and employment of leprosy patients, financial assistance for leprosy patients and their dependents, and compensation for disability incident to leprosy, respectively, comment relative to certain aspects of these provisions would seem appropriate.

Title VI of the bill would provide disability compensation for all leprosy patients who have completed their treatments and are physically disabled by reason of the disease or treatment therefor. The rate of compensation would be $125 per month for permanent total disability with proportionately lesser amounts for partial disability. The rate for total blindness incident to leprosy would be $150 per month. These rates of compensation, while lower than the compensation rates for veterans suffering from wartime service-connected disability, are higher than the rates provided for service-connected disability incident to peacetime military service. The basic monthly rates of compensation for veterans of World War I and World War II on account of service-connected disability range from $13.80 for 10 percent disability to $138 for total disability. That for peacetime veterans ranges from $11.04 for 10 percent disability to $110.40 for total disability. If the veteran's disability is rated total, he is entitled to additional compensation for dependents ranging upward from $14 a month for one dependent child, in the case of a war veteran, and from $11.20 a month in the case of a peacetime veteran. If the veteran's disability is rated less than total but not less than 60 percent, the additional amount is proportionately less. It is also noted that the compensation rate proposed for permanently and totally disabled leprosy patients is about double the monthly pension rates of $60 and $72 now provided by law for veterans of World War I and World War II suffering from non-service-connectetd permanent and total disability.

Under laws administered by the Veterans' Administration, veterans suffering from the disease of leprosy may receive disability compensation or pension on account of this disease, under certain conditions, up to $138 per month if blindness is not involved. If the disease results in total blindness, the rate of compensation may, under certain conditions, be $282 per month. Persons qualifying for compensation under the provisions of H. R. 4030 and also eligible for compensation or pension under laws administered by the Veterans' Administration would not, by the terms of the bill, be precluded from receiving duplicate monetary benefits from the Government for the same disability, although it has heretofore been the policy of Congress not to provide such double monetary benefits.

Another matter for consideration is the advisability of providing compensation as a gratuity to persons suffering from the disease of leprosy and their dependents without regard to other income of the recipient, as proposed in titles V and VI of the bill. Persons of income adequate for their support may become afflicted with leprosy. With respect to pensions for veterans of World War I or World War II suffering from permanent total disability not incident to the military service, Congress has provided that such pension shall not be payable if the annual income of the veteran exceeds $1,000 if single, or $2,500 if married, or if he has minor children. Similar limitations are applicable to the dependents of such veteran entitled to pension on account of non-service-connected death of the veteran. This bill contains no such limitation.

Title V of the bill proposes financial assistance for dependents of leprosy patients who are hospitalized for leprosy treatments and you may wish to compare the monthly rates proposed therein with those now provided by law for dependents of a deceased veteran of World War I and World War II whose death was attributable to his military service. The monthly rate proposed for the wife of a leprosy patient is $60, with $20 additional for each child. The monthly rate of compensation for the widow of a deceased war veteran is $75, with $25 additional for one child and $15 for each additional child. The monthly rate proposed for the children of a leprosy patient is $42 for one child and $20 for each additional child. The rates of compensation for children of deceased war veterans are $58 for one child, $82 for two children, $106 for three children, and $20 for each additional child. The proposed rates for widows, children and dependent parents approximate the death compensation rates for widows, children, and dependent parents of peacetime veterans dying from service-connected causes.

Under laws administered by the Veterans' Administration, no provision is made for the payment of compensation or pension to dependent brothers and sisters of deceased veterans, whereas title V of this bill would include dependent brothers and sisters along with the wife, children, and dependent parents, and such brothers and sisters are considered in the proposed rate for parents. In addition, the bill would apparently extend to dependent fathers-in-law and mothers-in-law who are not eligible under veterans' laws. The monthly rate proposed for one parent with no brothers or sisters is $50 and that for two parents is $68. One dependent parent of a World War I or II veteran dying from service-connected causes may receive $60 per month and two dependent parents may receive $35 per month each. The monthly rate proposed for a brother or sister of a leprosy patient is $42 with $11 for each additional brother or sister. Moreover, the proposed rates for widows and children exceed the death pension rates for widows and children of veterans of World War I or II who died from non-service-connected causes, and these latter benefits are subject to an income limitation.

The proposed program for rehabilitation and reemployment of leprosy patients as contained in title IV of the bill is somewhat similar to the Veterans' Administration program which deals with the rehabilitation and reemployment of disabled war veterans under Public Law 16, Seventy-eighth Congress, as amended. Section 202 (e) of the bill would authorize the Surgeon General to utilize the services and facilities of any executive department or agency of the Federal Government in carrying out the proposed program. If this bill should be enacted, it is possible that the Surgeon General might, to some extent, desire to use certain services and facilities of the Veterans' Administration, having in mind the knowledge and experience gained by this agency in carrying out its program of vocational rehabilitation of veterans. This presents a question of policy as to the advisability of making facilities designed to serve veterans available for groups which include nonveterans.

If the proposed legislation should be enacted and the facilities and services of the Veterans' Administration utilized by the Surgeon General for the purposes mentioned, additional personnel and funds would be needed since estimates of present staff and requirements for funds are based on the assumption that these will be used entirely for programs within the Veterans' Administration. It is noted that section 202 (e) provides that payment for services and facilities of another agency would be made as agreed upon between the Surgeon General and the head of the agency furnishing them.

So far as the Veterans' Administration is advised, legislation has not heretofore been enacted by Congress providing benefits for persons suffering from a specific disease or for their dependents similar to those proposed in titles V and VI of H. R. 4030. Therefore, the provisions of this bill relating to financial assistance for the dependents of leprosy patients and compensation for disability incident to leprosy would constitute an entirely new type of Federal legislation. In considering this matter it would seem appropriate to consider whether the enactment of this measure might lead to demands that persons suffering from other types of seriously disabling conditions and their dependents be granted similar benefits.

The Veterans' Administration does not possess information from which to estimate the cost of this bill, if enacted. It is assumed the Federal Security Administrator may be in a position to furnish data bearing on cost.

Advice has been received from the Bureau of the Budget that there would be no objection by that Office to the presentation of this report to your committee.

Sincerely yours,

CARL R. GRAY, Jr., *Administrator.*

STATEMENT OF J. HARDIN PETERSON, MEMBER OF CONGRESS, TO THE SUBCOMMITTEE ON PUBLIC HEALTH OF THE HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE

I represent the First District of Florida, and at the request of the American Federation of the Physically Handicapped I introduced H. R. 4030. After the various groups had a chance to study H. R. 4030 and had conferences among themselves, additional suggestions were made by the American Federation of the Physically Handicapped, which I embodied in H. R. 5234. I am advised that in these conferences were the Public Health Service, the Office of Vocational Rehabilitation, the Social Security Board, the Leonard Wood Memorial Foundation, the American Mission to Lepers, the Patients' Federation of the Leprosarium. It is felt that the latter bill is a much simpler method than the former. I understand that groups favoring the legislation will appear before you and I will not go into much detail, but I have gleaned the following information from those who have made a study of this situation which so much deserves our sympathy and our help:

Because of policy, the Public Health Service has not endorsed title VII, Financial Assistance for Leprosy Patients and Their Dependents. But because of the peculiar conditions surrounding leprosy it is urged that Congress give favorable consideration to the needs, in this instance.

Some 40 of our States have sent patients to Carville, La. A number of the patients at Carville are service men and women, who contracted this disease in the Pacific, in World Wars I and II.

At the present time, better facilities and trained personnel are needed to effect their cure, if possible, and to restore them to full status in our economic life. I would, therefore, like to urge favorable action on this legislation.

Mr. PRIEST. Dr. Stolar, give your identification for the record and you may proceed.

STATEMENT OF DR. ROBERT STOLAR, GEORGETOWN UNIVERSITY MEDICAL SCHOOL, WASHINGTON, D. C.

Dr. STOLAR. I am a private practitioner of medicine in the District of Columbia, and professor of dermatology and syphilology at Georgetown University Medical School, and consultant in dermatology and syphilology at the Mount Alto Veterans' Hospital, a consultant in dermatology and syphilology to the Surgeon General of the Army, assigned to Walter Reed, and senior visiting dermatologist and syphilologist to the Gallinger Municipal Hospital.

Mr. Chairman and gentlemen, to transmit a concept and to invite some questions, I have prepared a brief statement which I would like to read.

Mr. PRIEST. Very well, Doctor, you may proceed.

Dr. STOLAR. Leprosy, or Hansen's disease, in the light of our present-day knowledge, is a disease that affects the skin and the peripheral nervous system, but other tissues and organs are also infected, often early in the disease. Late manifestations of the liver, spleen, and other internal organs may occur.

Lesions of the muscles, bones, skin, hair, nails, and mucous membranes may not be directly due to the presence of mycobacterium leprae, the causative organism, but to trophic disturbances caused by nerve involvement. The disease is peculiar to man, has an extremely low degree of infectivity, a prolonged incubation period, and a chronic course often much prolonged, occasionally spontaneously remitting and arresting itself.

We have reached this present-day concept of leprosy after many centuries of observation in which time we have broken off specific groups of disease as they have fallen into repeated entities and have limited themselves, such as psoriasis, pellagra, and others. Because of ignorance and fear over the centuries, there grew up a body of restrictions, most prominently expressed in the Bible, which severely limited the activities and very specifically outlined the handling of these individuals with disease.

Hansen's disease today remains in a class alone in this country with the restrictions and legal prohibitions concerning it. There are only two States that treat it as it should be with no restrictions whatever and from an entirely medical point of view, New York and Massachusetts.

In dealings with patients, I have found that they will go to almost any lengths to eradicate a chronic or disabling disease. However, in leprosy, or Hansen's disease, I have found that there has been hesitancy with a few patients that I have handled. They did not wish to be incarcerated in an institution for the treatment of Hansen's disease, and the question came up as to how they could best be treated elsewhere. I believe that the disease could well be treated anywhere in the United States with no restriction on the movement of a patient whatever, and would only place very limited restriction and limited prohibitions in endemic areas, and only there under the supervision of his personal physician. For those unable to manage outside or for those so disabled that they were unable to care for themselves or be cared for by their families institutions should take them. The established institutions could handle them as they would any other chronic disease that they handle today, such as tuberculosis. This disease is much less communicable than average active cases of tuberculosis.

The difficulty lies in the attitude of both the medical profession and the laity. It was my experience during the war when I demonstrated such patients to groups of medical officers who had never seen Hansen's disease that they shrank from such a patient and did not wish to even come near. They had no concept of the disease. It was entirely a popular lay idea that they had. They had never received any instructions in their schools, and their attitude was colored by the use of the word "leper" associated with everything that was unpleasant, during their childhood, during various Biblical studies, and also in their daily living when people wished to use a term of opprobrium. They would use the term "leper" in that manner. With education, we soon altered the attitudes of the medical officers and they handled these patients and studied them well.

As recently as the last 2 months, we have had two patients in Washington with Hansen's disease and both of them at large medical institutions. One was a man who served in the Navy on Samoa in 1942, a native of Montana. Six years later he developed signs of the disease. He was the first patient with Hansen's disease most of the local medical officers had seen. The attitude with both patients initially was somewhat fearful. A little reassurance and elucidation of the status of the disease as it exists today and its lack of infectivity in nonendemic areas, changed the attitude. There are many such incidents.

An editorial in the Annals of Internal Medicine, the official periodical of the American College of Physicians for March 1949 opens with this statement, "Glider, parachute, submarine rescue, experimental diving, handling of lepers, demolition of explosives, observation flying." These categories were recommended for hazard pay by the Advisory Committee on Service Pay as recently as December 1948. When the justification for listing the demolition of explosive and the handling of lepers as comparable hazards was challenged, a spokesman of the committee defended the inclusion of leper handling on the grounds that hazard pay would compensate for "the fear of the disease felt by the average individual and the social stigma attendant to such service." It goes on to state that in the 54 years since the Leprosarium at Carville has been operating, no member of the medical or nursing staff has contracted the disease. This is the usual story in all leprosaria throughout the world. We must reorient the attitude of doctors and the public toward the disease. Much has been accomplished with magazine articles and some radio presentations, but much remains.

I am certain that people can be taught if there is a relaxation of the laws so that health officers are not compelled to carry out unnecessary, unscientific, and undesirable procedures in the management of patients suspected of this disease. Often the medical officers or health officers hide behind the law even though they do not believe that it needs such stringent measures. I believe that most of our population is highly immune, as manifested by the lack of spread of the disease in the other country than in the endemic States of Louisiana, Texas, Florida, and Lower California.

Once a patient has been stigmatized with the diagnosis of leprosy, it is almost impossible at the present time to remove the stigma from him and to allow him to carry on normal activity and normal work. I saw a patient during the war who had been stationed in New Guinea. He had been injured there, and at the end of a list of diagnoses, a medical officer put on the word "leprosy." Within a short time, instead of being at the end of the list, the term when it was seen by another medical officer was placed at the top, in spite of the story of the injury being so clear. This man was rushed rapidly from New Guinea by boat and plane across the Pacific and down to Carville. At Carville, he was examined and a diagnosis of leprosy or Hansen's disease was not sustained. After much communicating back and forth, he was sent from Carville to my service at the LeGarde General Hospital. At this place he was thoroughly examined by many medical personnel, more than the average patient, in an effort to give him a clean bill of health, and was given a clean bill of health and was discharged back to duty as a medical officer.

The first station at which he arrived he was questioned as to where he had been and what his previous stations were. The moment he mentioned Carville, he was immediately hospitalized and the officers in charge decided that they would not have him or handle him. Orders were requested from the Surgeon General's office as to what to do with him. It was felt that the problem would continue and that the situation would be repeated wherever he would go, and so this man without the disease was retired as having the disease with all of the attendant benefits of retirement. It seemed as if you could not budge the feeling or the emotional content of the feeling against the term associated with this man even though he did not have the disease.

Many factors in the spread of Hansen's disease are consistently evident. In spite of the tremendous numbers of M. leprae, the causative organism, and the ease with which they may be demonstrated in the lesions of lepromatous leprosy, the mode of transmission still remains unsettled. Certain important facts are worthy of elaboration.

1. Leprosy is not hereditary.
2. A high natural immunity occurs in human beings, especially in adults.
3. Children and the younger they are, are particularly susceptible to infection.
4. Not all cases of leprosy are contagious.
5. Prolonged and intimate contact is necessary for transmission.
6. No evidence exists that leprosy is carried by animal or insect vectors.

Today we have drugs which show excellent promise of arresting the disease and producing high beneficial results much more rapidly than any previous treatment. The patients that have received the sulfones since 1941 at Carville have responded well and the promise of other sulfones now under investigation certainly support the notion that treatment can be just as well carried out anywhere in the country and certainly much better in nonendemic areas. No restrictions need be placed on the movement of the patient.

It is certainly fitting to mention the great strides that have taken place in our altered thinking and handling of this disease by many individuals and the United States Public Health Service. The Public Health Service is acting rightly in accordance with both scientific knowledge and human feeling in its easing of restrictions. They are now allowing the patients to return home much earlier than before and also not incarcerating the so-called noncommunicable types. However, everyone concerned with the disease must be educated in regard to a disease to be feared less than many others and one to which no stigma attaches.

The revision of the attitude on the part of the authorities handling the disease as well as current advances in chemotherapy must be widely publicized. This disease is not a crime punishable by incarceration in institutions in isolated areas such as Carville has been until now. It must be handled as a disease, and this requires the best in scientific and humanitarian approaches. I am in favor of the least restriction placed upon any patient having a diagnosis of Hansen's disease and concur with all the provisions of the projected bill to further this aim.

Of all diseases to which man has fallen heir, none can use Burns' poetic description better than Hansen's disease when he said: "Man's inhumanity to man makes countless thousands mourn."

Mr. Priest. Thank you very much, Doctor.

Are there any questions?

Mr. O'Hara. Approximately what is the number of persons who are affected by Hansen's disease in the United States, do you know?

Dr. Stolar. The estimates, and they are only estimates, run anywhere from 1,500 to 5,000. I would doubt the larger number, and suspect that it is much closer to the smaller.

Mr. O'Hara. Is there any indication, Doctor, from the reports of any spreading of this disease, or is it about the same number, or what is the situation?

Dr. Stolar. Well, heretofore, prior to the war, the admissions to Carville, which is a good indication, have been relatively level. They have had approximately 400, or somewhat less than 400, patients over the last 20, 25 years, and the admissions have remained constant. They have discharged so many each year and admitted about an equal number.

However, in many areas they have been patients resident in those areas, in Texas, South Carolina, Florida, which are not included, as they have never gotten on the Carville roster.

Now, with the war, and men having been in many endemic areas throughout the world, and it seems as though most of the world, with the exception of northern Europe, has endemic areas, we will probably see an increase in the number.

I have recently seen one patient directly involved in the war, and another that is uncertain, but probably so.

Mr. O'Hara. From the time it takes after a person has been in what you call the endemic area, is that correct?

Dr. Stolar. Yes, sir, that means an area where it develops.

Mr. O'Hara. I suppose coupled with exposure to someone who has leprosy, do the two things follow?

Dr. Stolar. We do not know the transmission, whether it is exposure to an individual or to the environment where the organisms are present, or to some object in the environment. We do not know that. But the usual incubation period runs somewhere between 6 and 8 years, and is as low as 2 years and as long as 25 years.

Mr. O'Hara. The hopeful thing about your testimony, Doctor, it is all helpful of course, the hopeful thing is to learn that they effect cures, do they, or what would you call it at Carville? I noticed you said the discharges equal about the number who came in.

Dr. Stolar. In many of the chronic diseases, such as tuberculosis, syphilis, leprosy, and other of the granulamatous diseases, as they are called, the term applied is "arrested." In case such a patient relapses, then they try not to call them a cure initially, but say they are arrested and many such patients are sent out as arrested.

Mr. O'Hara. Do they go back into society generally? It that true?

Dr. Stolar. They attempt to go back. They are released upon society, but society has not been at all kind to the few that I know. The moment they have either gone back and hidden the fact that they have had the disease, or if some official agency of State or local Government learns that they have been exposed or have had the disease, then work becomes unusually difficult to obtain, and in most instances I would say impossible.

Mr. O'Hara. Some of that goes back to the biblical era, I suppose, Doctor, that dread of that disease, is that true?

Dr. Stolar. I would say it all goes back to that, and that in itself is an erroneous concept. It was an error in interpretation of a translation, following the translation from the Hebrew where the word "lepra" was translated in its original meaning of scaly disease, which covered many diseases, and the prohibitions in the Bible which allow the high priests to determine when a patient was well or not well included all diseases, and as we have lost our fears of other diseases, the one that has remained has been labeled with the term "leprosy."

We happen to have the chairman of the full committee, Mr. Crosser, sitting with the subcommittee this afternoon. Do you care to ask any questions?

Mr. Crosser. No. I am interested to hear the doctor's statement. That is what I came for. It was very interesting indeed. This is not a full committee.

Mr. Priest. Thank you for that correction and choice of words, Mr. Chairman.

Doctor, may I inquire if you can give the committee a rather definite idea of the extent of research presently being carried on in Hansen's disease in the United States.

Dr. Stolar. My knowledge of it is rather limited, but what little I know is this: There is some research being carried on at Carville, a very limited amount, and some at the School of Tropical Medicine at Harvard, a limited amount, with a lesser amount at New York University. Those are very small projects that are being handled, and I believe they could be well expanded.

Mr. Priest. Any further questions?

Mr. O'HARA. Doctor, would you be able to give us any estimate of what would be a fair governmental contribution towards the study and investigation of this disease, what would be required to start with? Do you have any recommendation you care to make?

Dr. STOLAR. I do not think I am qualified to do that. The question refers to money, is that so?

Mr. O'HARA. That is correct.

Dr. STOLAR. Money is something so indefinite to me when it comes to research that I do not know how to answer that question. I think it should be adequate; whether $100,000 or $500,000 is adequate, I don't know.

Mr. O'HARA. Is Carville operated by our Government?

Dr. STOLAR. Yes; that is the United States Marine Hospital, and handled or run specifically for the handling of leprosy.

Mr. O'HARA. Is there another island which is operated privately to which lepers are confined?

Dr. STOLAR. No; not in this country. That is the only leprosarium in this country, and it was selected primarily because of its isolation from all so-called normal humans. In 1921 that was done by a committee of the United States Public Health Service who were unable to place it in a more favorable location because of the popular feeling against the disease at that time. Other locations were selected, and one in Florida, but it was not allowed because it was too close to habitation of other humans.

At the time this was selected, it was about 15 miles away from the closest small village on the river, on the Mississippi and in swampland. However, the Public Health Service has transformed it now until it is a beautiful location. It certainly does not look like what it was originally. It is almost like a country club today in the set-up of the grounds. They have done a very fine job.

Mr. PRIEST. Doctor, very briefly, I wonder if you could give the committee some idea of the nature of the treatment that is used today?

Dr. STOLAR. Today the most successful treatments have been with the use of sulfones. They are a chemical. It is a first cousin to the sulfa drugs, and promine was the initial one used in 1941. Today that is given by vein every day, and it may take anywhere from 6 months to 2 or 3 years to obtain satisfactory results, and sometimes longer.

The next major drug was diasone, and that was given by mouth, and produces very nice results also. It has to be given over a long period of time.

The third that has been used is promisol, and that has been quite good in its effect.

Those are all sulfones that can be given by anyone or administered by any practitioner of medicine.

Then under investigation at the moment is promycetin, and that shows promise of even being a little better than the others. Then the British have a drug which they call sulfatrone, which is a tablet and given by mouth. These drugs are relatively expensive, however, and when I say relatively, I mean relative because last year about $22 was all that it needed to give a patient a year's supply of diasone, $22 to the Government was all that was necessary. Privately those medications are much more expensive, of course, and the value, however, to the patient is without estimation, as you can well judge.

Mr. PRIEST. Thank you.

Are there any other questions?

We thank you very much for your informative and helpful statement, Doctor.

Dr. STOLAR. Thank you.

Mr. PRIEST. Our next witness is Mr. Nick Farrell.

STATEMENT OF NICK FARRELL, FORMER PATIENT, CARVILLE, LA.

Mr. FARRELL. My name is Nick Farrell. It is not my real name; It is my alias.

When I entered Carville, La., they advised me to assume a name so as to protect my family. That started the subterfuge of my life, and what I am fighting against right now.

I was a patient at Carville, La., from January 6, 1944, to October 22, 1948.

Mr. Chairman and honorable members of the committee, I am here to present to this able body of Representatives the knowledge of cruelty imposed upon those who are living in this atomic age under rules and regulations based upon edicts handed down on the Plains of Abraham, which have made the National Leprosarium at Carville, La., a monument of man's inhumanity to man. Will it be necessary for a group of your fellow Americans to pay the price of ostracism, for themselves and families, in order to obtain treatment for their affliction? This ostracism does not cease, as I well know, even after one is discharged, but continues to hamper his efforts to lead a normal life.

H. R. 5234, the National Leprosy Act, introduced by Representative Peterson, will restore dignity to people whose only crime has been that they have fallen victims to the world's least communicable disease. We endorse all of the provisions in this bill, because we believe that it will surely bring about the early eradication of leprosy from this country, which goal we, the patients, are more interested in reaching than any other group concerned.

The provisions in this bill make it possible for victims of Hansen's disease to obtain treatment without humiliation or surrendering their civil liberties.

The medical aspects of this bill have received the endorsement of competent medical experts and Dr. Stolar has emphasized the need for research and trained personnel to diagnose and treat victims of this disease in the early stages. I shall therefore confine my remarks to the social aspects.

The unfavorable publicity and exploitation of the disease by both individuals, groups, and the press can and must be corrected by wide dissemination of the truth, which the Public Health Service will be authorized and compelled to make available. When this is done the cooperation of those who are not seeking treatment today will be assured. In my 5 years at Carville, acting as an official guide, and having toured some 5,000 to 7,000 visitors, plus my experience in the educational work I have been doing since my discharge, I find that the public is more than willing to accept the truth.

The need for vocational training and rehabilitation is sadly pointed out by the 57 individuals who have been discharged but remain in Carville because of skills lost and the lack of opportunity to gain new ones to prepare them for competition with other job-seekers. From my own experience and that of others we find that the stigma of having been patients at the Leprosarium eliminates us from obtaining employment.

When the breadwinner is taken away some provision should be made for his family and I have here a letter which will serve as an example showing what one patient is going through at this very time. This example is not the exception but rather the rule. If time permits I should like to read the letter to the committee and offer it as part of my testimony.

Mr. Chairman, this message is of the utmost interest to the committee, and with your permission I would like to read it.

Mr. Priest. Very well. You may proceed to read the letter.

Mr. Farrell. This letter is addressed to Dr. Otis Anderson, the Assistant Surgeon General of the United State Public Health Service, Washington, D. C. [reading:]

Dear Dr. Anderson—

It is by a patient of the hospital—

I should like to show through my personal experience the unnecessary emotional strain forced upon patients at the United States Marine Hospital at Carville, and the need that must be suffered by their families. I am a veteran of World War II, but do not get compensation. When I entered this hospital in April 1948 for further treatment of Hansen's disease, I left a wife and four children unprovided for. I believed that I could get one of the part-time jobs open to the patients, even though several jobs became vacant during the next 9 months, and I applied for them, and I did not get any of the jobs. I was, however, given some part-time work on several occasions, but this was so seldom that my family was without even sufficient food for several months, and my one boy who was of age did not have the proper clothes to attend school.

These facts made it imperative for me to return home, secure a job, and support my family. Although I had entered the hospital voluntarily 9 months before, it was necessary for me to leave at night through a hole in the fence, just like a criminal would.

Four months later I returned when I was assured by the Public Health nurse that she had talked with Dr. Johanson, the medical officer in charge of the hospital, and he had promised to give me the first available job.

Now the job of orderly in the physiotherapy clinic has been placed on the board and I applied for it, but it was given to someone else. I am once again in the position which forced me to leave the hospital previously. Strangely enough I am the only patient here who has the necessary experience in the job, as I went into the department without pay before leaving in 1948 to learn the work, and when the previous jobholder received his discharge early this month, I became his substitute until the job should be reassigned. Both the patients who received the treatment in this department and the physiotherapist in charge were complimentary about my work. On the basis of experience, proven ability, and need, my application would receive first consideration. When you consider that the patient given the job had another job at the time he was given the work and was not in need of it, it is beyond understanding. If I had received this job, I would have earned $88 a month. This is of course not sufficient to support a family of six, but it is the best paying job available to a patient if he is to work for the Government in this hospital.

Although these positions are labeled part time, they require 38 hours of work and until 2 years ago some of them demanded as much as 55 hours of labor and still it was labeled as part time work. Although patient employees are presumably on civil service and must sign all of the restrictive agreements, be fingerprinted and receive civil-service efficiency ratings, because we work 38 instead of 40 hours, we are denied any of the benefits of civil service, such as sick leave, vacations, retirement benefits, regular pay increases, or possibility of promotion. In addition, the pay scale is the same whether you are a broom pusher, a secretary, wheel the mop, or a school teacher.

Besides these benefits, a patient is automatically rated as 60 percent efficient. regardless of his education, training or demonstrated efficiency. I do not believe that this is equitable, because if a nonpatient were to hold the same job, for instance, as assistant in the physiotherapy clinic, it would be necessary to pay him at the rate of not 60 percent but of 150 percent efficiency, regardless of his ability. Certainly it seems that the patient should be at least rated on the basis of his ability. I am anxious to receive treatment, but it is impossible to receive my treatment here unless I can have the security of a steady job. I can probably get substitute work from time to time, but this is not sufficient to guarantee the needs of my wife and children. I could probably more adequately provide my family with an income by operating a private enterprise here. Until recently, when he was discharged, one of the patients operated a sandwich shop in the late evening. Since his discharge, and the close of the shop no one has been able to secure permission to reopen it. I am experienced in this work and might be able to earn a sufficient income from such an enterprise.

I hope that you may be able to aid me in some way, either that I may secure a Government job based on my ability to hold a position, and my need for such a job, and not on the basis of favoritism and prejudice, which seems to govern the granting of Government jobs at the present, or in granting permission for me to open a small restaurant and sandwich shop. I shall be able to remain here only on the basis of your assistance in this matter.

Sincerely yours,

JAMES A. CHERAMY.

An active advisory council as provided for in the bill is a must, if the provisions of this bill are to be carried out. The council will consult with the Surgeon General on new methods of treating this disease, both from a medical and social standpoint.

The patients at Carville are so interested in this bill that they made it possible for me to come to Washington by contributing towards my expense from their meager resources. Therefore, I am willing to submit to any cross-examination by the committee.

Mr. PRIEST. Thank you, Mr. Farrell.

Are there any questions?

Mr. Biemiller?

Mr. BIEMILLER. No questions.

Mr. O'HARA. Mr. Chairman, I have one or two questions.

Mr. PRIEST. Mr. O'Hara.

Mr. O'HARA. Mr. Farrell, would you care to indicate, if you know, how you got your disease? Would you care to tell the committee if it is not too personal a question?

Mr. FARRELL. I would be glad to give you a brief sketch of my life, if that is what you want. I am not a native of the United States. I have lived in Chicago for the past 15 years but I originally came from Europe, southern Europe, and I came from an area that the disease is endemic.

In 1932, when I came to this country, the early symptoms had already appeared, but they could not put their finger on it. For the next 10 years I stumped medical science in Chicago and within a radius of about 5 miles of Chicago. My disease was diagnosed eventually as syphilis. I was treated for 3 years, and that is not the exception, that is the rule with patients with this disease that 65 percent of us have either been diagnosed as having syphilis or treated for it, and that the drug given for syphilis is contraindicated in our disease and does us more harm than good.

I finally went to a major clinic; I went to Mayo Clinic, and I was diagnosed. On my letter of diagnosis, to show you how far the stigma in this disease has gone, on my letter of diagnosis the doctor who is the top dermatologist in Mayo Clinic tells my doctor to tell my acquaintances that I have a spot on my lung rather than to tell them the true nature of my ailment. The subterfuge began there.

I went to Carville, or rather I applied to go to Carville. In Illinois it is reportable; you have to report it. The physician has to report the disease to the State, and the medical officer comes after you after 30 days unless you report it yourself. I was isolated at the county hospital at Chicago for 1 week. I then demanded to go back home. They were giving me only one shot of chaulmoogra oil a week, and I was lying around in a room 7 by 14 and my family could not come to my room to see me. I finally demanded to go down to Carville, because my doctor was telling me of the sulfones, and he was giving me the chaulmoogra oil.

Finally, the Government red tape was cut, and 6 months later I got to Carville. I wasted another 8 months trying to get on the sulfones list; they were still giving me the chaulmoogra oil. I am discharged on the drug called promin.

While at Carville, when I entered the institution, I expected the medical board there to say, "Son, you are going to be here for a number of years; here is what you can do with your life."

Instead, when I got to Carville I found it was simply a stockade where people were turned loose and told to shift for themselves. There is no program for rehabilitation or vocational training. And if you had a skill, you would lose it in 5 years. Instead of a vocational rehabilitation program, we have a thriving gambling room, and more than one newspaperman has commented on that.

We, the patients, feel that we want to be accepted as normal members of society, as people who have had a disease and not the disease. Exactly what crime have we committed that we have to receive the treatment that we receive?

I have been discharged for 8 months now, and I am unable to find employment.

The Illinois Department of Employment, through their manager, through their district manager, advised me to use false references, not to tell my future employer the truth, but to get false references. Exactly what crime have I committed that I have to perjure myself in order to live a normal life?

I am living under an alias, I am doing all this educational work under an alias, because I am afraid of letting my community know exactly what is wrong with me, not for what they may do to me, but what they may do to my family. I have seen it, I have talked to patients down at Carville and I know what ostracization can be. You have three children right now in the State of Florida, who are children of a patient at Carville, La., who are completely free of the disease. They have been examined every 6 months and do not have the disease and yet they cannot enter the public schools. They will not even be accepted in an orphanage and are living in the home of an aged couple who are not qualified to take care of these children and all this because of unreasonable stigma, because of ignorance of the general public.

It is high time that the Public Health Service who have restricted this problem themselves to get out and do an educational publicity campaign. We feel that if they had done 1 percent of what they had done for syphilis, today we would be accepted as normal members of society. We do not want a dole, we want to be treated as citizens, as we are. We do not want to have to lose our civil rights. I do not want to have to hold my head down to anyone. I am an American citizen and I am willing to earn my own way; I want that opportunity. I want that opportunity not only for myself, but for everyone else who is afflicted with this disease.

We at Carville publish our own publication which with your permission, Mr. Chairman, I would like to enter into the record because of the articles in our publication which bear upon my testimony and which can substantiate many of my facts.

Mr. PRIEST. The committee will receive the publication either for the record or for the file. If it is not too bulky, it will go in the record, otherwise we will hold it for the files of the committee.

Mr. FARRELL. Thank you, Mr. Chairman.

(The information referred to above has been placed in the committee files.)

Mr. FARRELL. I would like to say in conclusion that the patients at Carville receive countless letters from all over the world from people who look upon the United States to be leaders in changing the situation all over the world. They say if a country as enlightened as the United States does not pass sane legislation, how can we expect our country which is still in the horse-and-buggy days to do it.

So, it is a mission, it is a mission, it is something we should have done a long time ago and it is something that we, the patients, would like to have your committee do now, right the injustices and restore dignity to people with Hansen's disease.

Mr. O'HARA. Do you have any recommendations as to a change in the form of operation so far as rehabilitation of the patients at Carville?

Mr. FARRELL. Well, at Carville, La., there you have people from all strata in life. For instance, you have to teach them a trade which they can probably carry on when they leave. This is a chronic ailment and it does take something out of you. If a man was a ditch digger before he went to Carville, he cannot go back to ditch digging or he will have to go back again. Let us teach him a skill.

We think also that while the patient is down there we have 135 trades represented at Carville that they could do much of the work that is being done down there now by the personnel, by the people whom you are paying not 100 percent wages but 150 percent.

We feel that we have Texas cattlemen down there who could just as well take care of the herd of cattle, we have painters, carpenters, electricians who have little businesses there and do special painting and who are capable of doing much of the work that is going on at Carville. I want this that when a breadwinner is taken away from his family, when society demands that that breadwinner be taken away and that family is left destitute, does that person not have a right to take care of his family either by his income or the Government take care of them?

Mr. O'HARA. It appears to me that if there is a job there that he can do, it would be much better for him.

Mr. FARRELL. Exactly.

In the first 8 months before I got interested in the publication down there, I had plenty of time on my hands. Since I started working with the publication and doing promotional publicity, I find that I could have used another 24 hours a day. The patient is much happier under those circumstances because it gives him something to look forward to. If you are busy, you do not have the time to think about what is wrong with you. We would rather have it that way.

Mr. PRIEST. Mr. Sadowski?

Mr. SADOWSKI. How much time did you spend there altogether?

Mr. FARRELL. About 4 years and 8 months.

Mr. SADOWSKI. How long after you began receiving these drugs that you speak of, did your condition begin to improve?

Mr. FARRELL. Sulfone drugs.

Mr. SADOWSKI. Did your symptoms begin to vanish?

Mr. FARRELL. Oh, about 4 months afterward. I had nodules over the lower part of my face and they started disappearing, the thickening of the skin on the eyebrows began receding and my tests showed less and less germs as I absorbed more and more of the treatment. Today it is a crime, it is a crime because today we have these drugs and yet this very system that we have set up keeps people 50 miles away from the hospital, away from treatment. We have patients at Carville today who write home and tell other members of the family who have the disease, "Do not come to Carville. Do everything possible to get the treatment outside, but do not come to Carville. Do not be branded a leper." That is what they mean, and that situation has to stop.

If we are interested in an ultimate goal of eradicating the disease from this country, and if we have failed to bring the drug to the patient, then let us bring the patient to the drug.

Mr. SADOWSKI. How long after receiving these treatments did your symptoms disappear entirely?

Mr. FARRELL. Entirely, about 4 years. That varies; some patients have lost their symptoms completely in 2 years. It depends on getting the person to the drug as soon as possible after he has been afflicted with it. Patients, in order to avoid the stigma, hide as long as possible until they can no longer hide their disease, and then they go to Carville, and that is the thing you want to eliminate.

Mr. BENNETT. You said you were there 8 months before you could get this sulfone—was that due to a shortage?

Mr. FARRELL. I guess because it was still in the experimental stages and the firm was not making enough. Now chaulmoogra oil has been done away with and they have the sulfones.

Mr. BENNETT. Are plenty of them available?

Mr. FARRELL. Plenty of them are available, but the new drugs that are still being tried are short. They only have a group of 20 patients that they use as an experimental unit. This promoset, this new drug, I saw a fellow come in there with his hands puffed and he was expected to be 8 months before he could go out and play ball with us. Under the new drugs in 2 months he reported for spring training and he is pitching ball for us three times a week, and that is how wonderful those drugs are.

I want to call to the attention of the committee that you are not speaking of people who are bedridden, they are ambulatory; 90 percent of those people go out and live a normal life as you do or try to. I have worked 8 hours a day there, gone out and played a round of golf, played on the ball team, and danced that night. Fifty percent of our patients are as active as any youngster today. To keep them cooped up and not allow them the opportunity to develop themselves is a crime.

Mr. Bennett. Did you notice many cases that had been discharged as cured and then returned for further treatment while you were there?

Mr. Farrell. Not since the sulfones. Your old chaulmoogra-oil cases, some came back. In the sulfones, I imagine there is less than five that have returned, while under the chaulmoogra-oil days quite a few of them came back. Some of them come back because of economic reasons, but not because they have the ailment, not because they are positive again. They come back because they cannot make a living outside.

Mr. Sadowski. Do those people that are cured and come back, do they obtain better jobs than the patients?

Mr. Farrell. The job situation at Carville, there is not enough of them. There are 400 patients in Carville and only 128 Government jobs, and possibly another 40 that are created by patient enterprises, and that does not cover it. That $88 a month, which is top salary, certainly you cannot raise a family of a wife and four children on it.

You will say: Why do they not revert to State charity? When they revert to State charity they have to let every fact be known and then the family is ostracized.

I was entitled to money after I left my work, I had some sick benefits coming but I let it go by because I did not want to have it known at the plant that I had this ailment; that is the stigma of it; that is what we are trying to get away from. What we want is to be treated like human beings. When you cut us we bleed just like the next person.

Mr. Bennett. Do they give you different kinds of discharges from Carville; that is, whether you are an arrested case or completely cured?

Mr. Farrell. No; you are never called completely cured, as Dr. Stolar said. They say you are arrested. However, I have had no recurrence of anything.

Mr. Bennett. Do they ask you to come back for recheck?

Mr. Farrell. I am supposed to check every 6 months. I have actually been examined by private physicians but the Health Service has not asked that I go in for check-up. I am interested in staying out and that is why I have my check-ups. The whole situation needs direction and we have to break up that status quo down there.

Mr. Bennett. How many patients are in the institution who are regarded as completely arrested?

Mr. Farrell. Fifty-seven at the latest count. Some of them are physically able to come out and actually carry on a normal life. Some of them have been badly maimed by the disease so that they remain in Carville. In their remaining in Carville, it is costing you and us the taxpayers over $10 a day. If you gave them $5 a day, they could probably go home and live and be a lot happier and make room for other patients.

Mr. Bennett. Thank you.

Mr. Priest. Mr. Biemiller?

Mr. BIEMILLER. In addition to the Biblical allusions which have been referred to by you and which have probably laid the basis for the unfortunate social mores in regard to this disease, I also have a recollection as a youngster of reading the story of a heroic Catholic priest who went to the leper colony in the Philippines.

Mr. FARRELL. You are referring to Father Damien on the island of Molokai.

Mr. BIEMILLER. I am frankly now trying to look back into my own childhood to see where these attitudes that we have come from. As I recall that story it left the impression that leprosy was a great dread disease and particularly a contagious disease.

Mr. FARRELL. That is right.

Mr. BIEMILLER. I am wondering, has that story unfortunately also played a role in developing the current mores on the question?

Mr. FARRELL. It has played a big part in this misconception. Father Damien did a wonderful thing, and Molokai, I cannot find words to describe it. I have read other peoples' descriptions but it was a hell hole. He went there and the fact that he got the disease put the place on the map, but today the very fact that he got the disease in 16 years that he was there is haunting us.

No one ever remembers about Father Dutton, his successor, who was there for 44 years. No one ever remembers about Sister Polladina who was there for 30 years. They did not come down with the disease. Father Damien, unfortunately knew very little about hygiene and one thing they agree upon is that he smoked the pipe of patients, that he slept in the same huts, and that he had his food cooked. They ate from one big bowl and everybody scooped in and there were no hygienic precautions taken whatsoever.

You would be surprised at how easy it is to get into Carville today. Visitors walk in, they are turned over to the patients and I take them and I leave them and they are not even asked to wash their hands. I am just showing what the difference is. There are practically no precautions taken today, but the person does not sleep with them today and they do not get the ailment. At Carville we have had the nursing staff there and the doctors there for 55 years and no one has ever come down with the disease. What tuberculosis sanitorium can give you the same record? Every year doctors and nurses who work with patients break down with tuberculosis and nothing is said about it. But let one case of this type occur and your journalism blows it up all over the country.

Mr. BIEMILLER. I certainly agree that the facts about this disease should be much better known than they are, the scientific facts, because as I have just been stating as a lad you got the idea that Father Damien knew he was accursed with the disease and I think it has left an impression with probably thousands of people to whom the story was told as a heroic move on Father Damien's part.

Mr. FARRELL. Yes.

Mr. BIEMILLER. But the impression has been left that he foreordained his own doom by associating with lepers.

Mr. FARRELL. You see it up to 2 years ago and probably you will see it 2 years from now when some sisters will leave for some far-off colony for Hansen's disease. "Sisters Go to Living Death," or a headline of that type. It is unfortunate that some organizations, in order to collect funds for overseas work have exploited the word leper and leprosy and that is why we want the word changed. It is not scientific and it is not descriptive of our disease. Leprosy is no more active than if you gave it the name of Ford or any other name. It is not descriptive of it and why should we be saddled with the stigma that these words have gathered?

There is a movement underfoot now in the AMA to change the name of the disease. The committee on nomenclature of the American Medical Association is seriously considering changing the name and they are coming to the realization that the name is more harmful than the disease itself and so progress is being made.

Mr. Priest. I believe Mr. O'Hara has another question.

Mr. O'Hara. No questions.

Mr. Priest. The committee is very happy to have present as a visitor on this occasion the Honorable Overton Brooks, from the State of Louisiana. We would be very happy to hear from Mr. Brooks or have him put any question that he might care to ask.

Mr. Brooks. Thank you very kindly, Mr. Chairman. I have no statement to make but I do want to thank the committee, each one individually, for listening so well to the testimony of this gentleman on Carville.

I am familiar with the situation at Carville and I became very much interested a number of years ago when the American Legion took this matter up as a part of the program of the American Legion and I can truly say that the American Legion does not do any finer work on any program than it does in trying to correct the situation down in Carville, La.

I am glad to see that they have a special committee here for that purpose. I listened very attentively to every word that has been said by this young man and I do not believe anybody can improve on this testimony.

Thank you, Mr. Chairman.

Mr. Priest. Thank you, Mr. Brooks.

Mr. Farrell, is there a leprosarium that you have knowledge of in the Canal Zone, somewhere near the Pacific side of the Canal Zone?

Mr. Farrell. The United States Government actually through its Territories is responsible for several colonies. They maintain one called Paulo Seco in the Canal Zone and by agreement with the Panamanian Government they also take care of their patients. Dr. Horowitz, I believe, is the MOC there, the medical officer in charge.

Then we have also a colony in Christianstedt in the Virgin Islands where I think there are 30 patients there at the present time.

Of course we are indirectly responsible, I believe, for the colony on Moleki and it may be of interest to the members of the committee to know that Moleki will be abandoned; that there is a movement underfoot to abandon Molokai and to establish a clinic in Honolulu which will be closer to the medical profession.

You see, that has always been one of the things that has been seriously wrong. Why place an institution 85 miles from nowhere or 100 miles from nowhere? Place it close to a medical school whereby doctors can learn what it is all about and can lend their talents. That is what we have wanted to have. Why was not Carville built close to Tulane, a university with one of the best medical schools in the country, where they could have had consultants from that school? Instead, it is a place 85 miles from that school.

I might also add that in Hawaii the legislature has passed a law which changes the name of this disease from leprosy to Hansen's disease. That was passed by the last session of the legislature.

Mr. PRIEST. Are there any further questions?

We thank you very much for your appearance before the committee and I am sure the committee appreciates the earnestness and zeal which you have shown in the work which you are doing. We hope that in some way we may be helpful in that work. Thank you.

Mr. FARRELL. Thank you, Mr. Chairman.

Mr. PRIEST. There are two other witnesses who had at first expected to be present today but cannot be on hand and have requested that they be allowed to file statements.

I have a statement here from Dr. Eugene R. Kellersberger, referred to by Mr. Farrell as one of the leading authorities on this subject and without objection his statement will be included in the record.

(The statement is as follows:)

STATEMENT FILED BY EUGENE R. KELLERSBERGER, M. D., GENERAL SECRETARY, AMERICAN MISSION TO LEPERS, INC., NEW YORK, N. Y.

For 43 years the American Mission to Lepers has been deeply concerned about the physical, mental, and spiritual welfare of those afflicted with leprosy around the world. It has been a pioneer, together with the Mission to Lepers in London, for three-quarters of a century in establishing leprosy homes, dispensaries, and clinics, agricultural colonies, uninfected children's homes, and in doing a practical, clinical research work through its doctors and nurses who are always medical missionaries. This work is being carried on through all the Protestant mission societies of the United States and Great Britain. It has done a large and important work in preventing leprosy in children and in teaching the world the truth about the disease. It has trained many workers throughout the world to help bring to the attention of everybody the unhappy and intolerable lot of some five to ten million of our fellowmen. It cooperates fully with all governments.

This mission, through its various avenues of publicity, has often expressed itself as definitely favoring the enactment of a new national leprosy act, correcting present archaic laws and removing unjust provisions that are out of date and that defeat the very purpose for which they were enacted. H. R. 4030, as presented by Col. George H. Rarey and Mr. Paul A. Strachan of the AFPH (American Federation of Physically Handicapped) has in it many fine features that commend themselves to all of us. There are, however, some provisions which require close study before they are fully accepted by all who are interested and have the responsibility of carrying out the provisions of the act.

As a member of the Surgeon-General's Advisory Committee on Leprosy in the United States the writer has constantly regretted that excellent and exhaustive study of this problem by the AFPH was mostly done apart from close consultation with the Public Health Service, which is directly responsible for this program at the present time and has been for 50 years. I have insisted that the lay and medical leaders concerned in developing this most important program must work out together with the Public Health Service and others concerned a constructive act that will result in many much-needed changes, yet remain an act that will have the full cooperation of all groups. I consider it essential to fully consult with the Public Health Service, with its invaluable experience and faithful service at Carville for the past 50 years. This view was evident in the findings of the Senate hearing committee on bill 704. As a result of this hearing the leaders of the federation and the Public Health Service were instructed by Senator Pepper to go into conference and to submit an act arrived at after full consultation with all who are so deeply concerned.

We are in hearty accord with the provisions which advocate financial aid for the dependents and compensation for the physically disabled discharged patients and provision for rehabilitation and training. We agree that the education of the medical profession and the general public is essential and that research work must be intensified. We favor abolishing forced segregation and substituting for it voluntary treatment based on early diagnosis and confidential treatment of such as apply for help, as is done in other diseases. We cannot agree that at present it is necessary to spend several millions of dollars to build another large institution in a nonendemic State since, in general, we do not believe that leprosy is an institutional disease or one which as a rule requires hospitalization. We agree with Dr. Perry Burgess that not enough use is being made of existing facilities throughout the country where hospitalization or dispensary treatment can be provided. We believe that in every large city there should be diagnostic centers such as have just been established in the city of New York, to study tropical diseases, and that this should include a definite study of all possible cases of leprosy. Furthermore, these cases of early leprosy should be referred for study, classification, and treatment when possible to the dermatological clinics of medical schools and hospitals. More and more such cases, being assured of privacy and the absence of stigma, would cooperate with the authorities and with the present therapeutic help and with the social-service follow-up. More and more cases, also, would be reached early. It would thus be unnecessary to send them to an institution. For such as do have to go, the present magnificent plant at Carville would still serve fully.

We wish to give testimony to the earnest efforts of the leaders of the American Federation for the Physically Handicapped in trying to obtain justice for our friends afflicted with this ostracizing disease. We further wish to go on record in commending the excellent and devoted medical and nursing service that has been given through the years at our great National Leprosarium by its medical, technical, and nursing staff, a part of the United States Public Health Service.

Mr. PRIEST. I also have a statement here from Mr. Perry Burgess, who is president of the Leonard Wood Memorial. Without objection, his statement will be included in the record.

(The statement is as follows:)

STATEMENT OF MR. PERRY BURGESS, PRESIDENT, LEONARD WOOD MEMORIAL (AMERICAN LEPROSY FOUNDATION), NEW YORK, N. Y.

The Leonard Wood Memorial for the Eradication of Leprosy was incorporated in the State of New York in 1929. It carries the name of the great American soldier, Gen. Leonard Wood, through whose efforts the condition of leprosy patients in the Philippines was greatly ameliorated. The memorial is supported entirely by gifts from the public. The chairman of the board of directors is the Honorable Henry L. Stimson. Since 1931, under the guidance of an advisory board of distinguished medical scientists, the memorial has devoted itself to scientific studies of leprosy. It has a research laboratory at the Culion leprosy colony in the Philippines and another at the Harvard Medical School. Studies of the home and other environmental conditions under which the disease occurs have been carried on in the Philippines since 1933. Grants have been made to research workers in a number of leading medical centers. Fellowships for study in the United States have been given to a number of foreign leprosy workers, and aid to several international congresses on leprosy. A scientific publication, the International Journal of Leprosy, is subsidized by the memorial.

In the United States, leprosy is indigenous only in southern California, Florida, Louisiana, and Texas. There are about 400 patients under treatment at the National Leprosarium at Carville, La. The number not under treatment at Carville is variously estimated at from 300 to 1,500, making a maximum estimate of 2,000 patients for the continental United States. Judging from admissions to the National Leprosarium there is no reason to suppose that the disease is increasing or decreasing. Of 703 patients admitted from 1928 to 1944, 420, or 60 percent, were born in the United States.

In my opinion H. R. 4030 has many good features. There is a great need for a more enlightened public opinion as emphasized in section 101. The contagiousness of the disease is certainly less than that of tuberculosis, yet extreme and harsh measures are often taken in the name of public health when an individual is discovered to have leprosy.

Title II is designed to make treatment more readily available by authorizing the Surgeon General to provide for treatment in Veterans' Administration hospitals, in State, county, and city hospitals and, in certain instances, in the homes of the patients.

It is my understanding that most of the cases now being detected are moderately or far advanced on discovery and it is in the best interest of the patients to be placed under the care of physicians and nurses experienced with the disease. In the present state of public enlightenment regarding leprosy, moreover, there might be administrative difficulties imposed upon general hospitals in caring for occasional leprosy patients.

After a period at Carville, however, many patients might be taken care of by their own physicians or by out-patient clinics, including even some who are still infectious. Under these circumstances provision should be made for the payment of physicians and for necessary drugs as is contemplated under section 211.

Before committing myself as to the soundness of the proposal in section 214 to establish five additional leprosy-treatment centers, one in a nonendemic State, I feel that there are certain questions which should be answered. Among these are:

1. Is there need for another institution in Louisiana when the present National Leprosarium at Carville is not filled to capacity? Or, if another institution is necessary, would it not be adequate to provide suitable accommodation at the present United States marine hospital at New Orleans?

2. Similarly, if an institution is necessary in Texas, would it not be adequate to utilize the present United States marine hospital at Galveston?

3. As regards the proposal to authorize an appropriation of $1,500,000 for a 200-bed institution in a nonendemic State, is it desirable to authorize such an appropriation before ascertaining the number of patients available and willing to go to such an institution? If such an institution were established, it is possible that more patients would seek treatment earlier in the disease than at present. If this be probable then of course I would favor it. I should point out, however, that the recent tendecny in leprosy control, where the policy of segregation is adopted, is to place treatment centers as near the homes as practicable. In 1906 the Culion colony was established in the Philippines at a very remote and inaccessible site and all infectious patients were sent there. This led to much distress on the part of patients and their families. A few years before the outbreak of World War II a policy of decentralization of institutions was adopted and there are now eight in different parts of the Philippines. Brazil, which is probably doing more than any other country with a large number of patients, has 37 leprosaria for about 25,000 patients. As for the beneficial effect of climate on the disease I am not aware that there is a higher discharge rate for institutions situated in cool climates than for other institutions. At the same time I recognize the comforts of a cool climate and am suggesing only further consideration of this important proposal.

The measures for rehabilitation which are proposed in sections 401–412 are good except I have some question regarding the practicability of developing a training program for an individual or a very small group. I have learned with much interest that a program of physical rehabilitation and training has been initiated at Carville. A perhaps minor point in the bill is that the Surgeon General is charged with developing a program of reemployment which shall "include plans to obtain the cooperation of Federal, State, and other employment agencies, corporations, and businesses in placement of employable discharged leprosy patients." The success of any such effort, in my opinion, must depend upon gradual education of the public, as in tuberculosis. The present wording might be interpreted as making such cooperation mandatory on the part of various other Federal agencies, and perhaps it would be preferable to insert the word "voluntary" before the word "cooperation."

In many instances patients delay going to a physician, and in some instances leave Carville against medical advice, because they are worried about the financial needs of their families. Leprosy is peculiar in that males are much more frequently attacked than females which means that more often than not it is the breadwinner who goes to the leprosarium and who remains there for years and sometimes for life. I am in sympathy, therefore, with some system of grants for dependents, but I am not competent to pass upon the precise provisions of sections 503–512. I am likewise in sympathy with the proposal of sections 601–605 to compensate discharged patients who are physically disabled.

The greatest need in leprosy is further research. It is estimated that there are from 3 to 5 million persons suffering from leprosy in the world, and while vast sums are being spent for their subsistence and treatment only a paltry amount is spent annually in search of methods of prevention and cure. I know of fewer than a dozen scientists in the world devoting full time to leprosy research. I consider that larger sums than those proposed in H. R. 4030 could be spent profitably for these scientific studies which are fundamental to the solution of the whole problem. The medical board of the Leonard Wood Memorial considers that work should be carried on in three directions, viz, (1) attempts to cultivate the leprosy bacillus, thereby facilitating the preparation of a possibly effective vaccine; (2) field studies to learn more of the environmental conditions in which the disease occurs; and (3) clinical trials of new drugs and antibiotics.

There is a paragraph in the research section of the bill [section 701 (b)] which should be modified or struck out. This paragraph charges the Public Health Service with the duty of conducting and supervising the national research effort. The Public Health Service has done a great deal of notable research on leprosy but so have certain nongovernmental agencies. It is my understanding that the policy of the Service is to assist and encourage, not to conduct and supervise the work of other agencies. Since the duties of the Surgeon General are well covered in section 702 (a) I would suggest that section 701 (b) should be admitted.

In summary, I would like to emphasize what I consider to be especially good objectives of H. R. 4030: (1) Emphasis on education of physicians and the public; (2) provision for treatment at home, especially after preliminary treatment in an institution or treatment center; (3) financial aid for dependents; (4) compensation for physically disabled discharged patients; (5) provision for rehabilitation and training; (6) financial aid for research.

In conclusion, may I say a word of commendation for the excellent medical and nursing care at the National Leprosarium at Carville. As you know, the medical and technical staff are furnished by the Public Health Service and the nurses by the Sisters of Charity. The devotion of all classes of personnel to their responsibilities cannot be too highly commended.

Initiation of the use of the sulfones in treatment of leprosy and demonstration of their superiority over older drugs, should be credited entirely to the late Dr. G. H. Faget and his associates of the Public Health Service. Their efforts have been inspirational, and are being emulated by workers throughout the world.

Mr. PRIEST. There is also a very brief statement on this subject submitted by Col. G. H. Rarey, United States Army, retired. He desires that his statement be included in the record and without objection that will be done.

(The statement is as follows:)

STATEMENT OF COL. G. H. RAREY, UNITED STATES ARMY, RETIRED, DECATUR, GA., ON NATIONAL LEGISLATIVE PROGRAM OF THE AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED

H. R. 4030, The National Leprosy Act, introduced by Representative J. Hardin Peterson of Florida,.

The purpose of this bill is to break down and overcome the harmful effects of the ancient leprosy stigma, allay and finally eliminate lepraphobia, and bring this disease under a firm control in the United States.

To accomplish this purpose the American public will be shown that this illness is not the very contagious and relentless menace they have believed it to be, and, therefore, that their unreasonable fear of leprosy is not justified. Our people must and will be shown that their unreasonable fear of what is, in reality, a feebly communicable disease, is the main factor now holding up progress in bringing it under control. The above-stated purpose will be accomplished through the operation of the National Leprosy Act, which provides:

(1) For an educational program designed to acquaint the public with the truth about leprosy, and to provide the medical profession with authentic information concerning the diagnosis and treatment of this misunderstood disease.

(2) For modern treatment methods and practices based upon the exceptionally low degree of communicability of the disease, and upon the status of each case when diagnosed.

(3) For a National Advisory Council to help bring the disease under control.

(4) Family allowances for dependents of hospitalized patients (because of the unusual family problems involved in the hospitalization of these patients).

(5) A Rehabilitation and Reemployment Program for hospitalized patients.

(6) Compensation for disabilities incurred incident to leprosy.

(7) For an expanded leprosy research program.

Dr. Richard C. Cabot, professor of clinical medicine, Harvard University, has summarized the United States leprosy situation quite accurately, as follows: "Leprosy is a disease which it is almost impossible to catch, but, unfortunately, the public has very much the opposite idea, so the leprosy victim has been, I think, disgracefully, very expensively, very stupidly treated, by extreme isolation. This isolation is because of superstitions on the part of the public that a leprosy victim, who almost never gives anybody disease, should be shut up tight, while syphilitics and the tuberculous go free. This is one of the paradoxes and abominations of our system. A very unintelligent and very stubborn prejudice still persuades people that leprosy is a highly contagious disease. It is not impossible to catch it, but it is one of the least contagious of all diseases, and we are exposed every day to more contagious ones."

Mr. Priest. Our next witness this afternoon will be Mr. Paul A. Strachan.

STATEMENT OF PAUL A. STRACHAN, PRESIDENT, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, WASHINGTON, D. C.—Resumed

Mr. Strachan. Mr. Chairman, I wish, in the absence of Representative Peterson, to give the committee the information relative to the reasons why we are now discussing a substitute bill for the original Leprosy Act.

At the time this matter was before the Senate, the Public Health Service, the Leonard Wood Memorial Foundation, the Patients Federation, and our own organization presented testimony along with that of eminent physicians, epidemiologists, and others. The first bill, Mr. Chairman, was drafted by a man who is a zealot on this subject, Col. George H. Rarey, who spent 17 years in the Orient while in the Army and who had become determined to do something about the leprosy situation.

When he was discharged after some 40 years of Army service, 3 years ago, he began to put together the pieces of this jigsaw and is deserving of great credit for the superlative research job, and he wrote a bill which I privately considered was much too long and too prosy but I am sure you will all understand that we each have our idiosyncrasies and his in this instance was a bill which was a little bit off the beam.

So, the Senate committee, having heard testimony, urged and in fact almost laid a mandate upon all present to get together and get one bill up that we could all agree upon. That was a pretty large order but several conferences were held and the net result is a bill which was just introduced day before yesterday and on which only today prints became available. This bill is H. R. 5234 and we ask that henceforth the committee consider this bill rather than the predecessor bill.

I wish to explain for the benefit of the committee that down to section 501 of this bill was written by and approved by the Public Health Service and the other organizations interested went along.

The sections, National Advisory Council on Leprosy and the title on medical research, we urged that the Assistant Surgeon General, Dr. Anderson, take this matter back to the Surgeon General, Dr. Scheele, for approval because we said, and I submit that you can see our point, the treatment of leprosy is in a somewhat different category than any other disease and that, therefore, we think it should be wrapped up in one package.

The committee is not opposed to this idea, but the Public Health Service felt that they could not endorse this in Dr. Scheele's absence.

The last section relates to financial assistance for leprosy patients and their dependents. Mr. Chairman, I have watched Congress for 36 years and perhaps mistakes are made because Congress is composed of human beings and human beings are not to be classed as perfect, I know. But, I will say this: Having dealt with Congress for many years, in the long run we always get a fair break if we come to you in equity and ask for justice.

Now I realize that the Public Health Service as a matter of policy cannot recommend or would not recommend, payments to leprosy patients and their dependents. That is a matter, however, as I told the Public Health officials, that they have no right to sit in arbitrary judgment upon, it is a matter for the Congress itself, taking into consideration the peculiar conditions, to determine.

I, therefore, urge that this committee give serious consideration to affording some kind of financial assistance as we ask for here, simply because if the breadwinner is taken away, as the previous witness explained, it does produce a very unhappy situation and if we are moved by nothing but humanitarian principles, I feel that the Congress in its wisdom will do something along this line.

As the representative in this instance of the Patients Federation, as well as our own organization, and because I have been a little repetitious here in my appearance today, but through no fault of my own, I want to thank the committee for the courtesies and interest it has shown to all those who have appeared on the various bills today, all of whom were brought before this commitee at the instance of the federation I represent. I want to thank the committee very kindly and I say that it is a privilege to appear before you. I will be glad to answer any questions that I am able to answer.

Mr. PRIEST. We certainly thank you for this splendid cooperation which you have given in arranging for witnesses and for all other instances in which you have cooperated with the committee.

Mr. STRACHAN. Thank you.

Mr. PRIEST. Any questions?

Your prepared statement will be inserted in the record at this point.

(The statement of Mr. Strachan is as follows:)

STATEMENT OF PAUL A. STRACHAN, PRESIDENT, AMERICAN FEDERATION OF THE PHYSICALLY HANDICAPPED, WASHINGTON, D. C., ON H. R. 5234 (MR. PETERSON, OF FLORIDA), NATIONAL LEPROSY ACT

Mr. Chairman, as has been explained by Representative Peterson, the present substitute bill has been an evolutionary process. In campaigning for this program, I have found Members of Congress really desirous of assisting those afflicted with leprosy, and there only seemed to be a comparatively small difference of opinion separating the Federal agency at interest, Public Health Service, and our organization and other organizations who represent various phases of the leprosy problem.

So, I was glad when the Senate committee laid a virtual mandate upon all these groups, public and private, to get together and endeavor to work out a bill that would meet the needs of the times, and yet, not be too far off the beaten path in legislation of this sort. In the conferences there was considerable give and take, and I think the present bill, H. R. 5234, offers a fair substitute.

It should be understood, as Representative Peterson has said, that while the principles of the proposed National Council on Leprosy, and Medical Research are recognized by the Public Health Service, yet, they have not cleared these matters, because of the absence from the city of the Surgeon General. On principle, Public Health opposes payments to patients, but, this is a matter which, I think, lies in the province of the Congress to settle, and I so told Public Health officials. The fact is, here is a grievous condition which should be remedied. If the Public Health Service will not recommend such plan, that does not mean that the plan is unworthy, or that the Congress should not approve it, and I place my reliance in the judgment and humanitarianism of the Congress.

I have previously suggested to Members of Congress that a committee should visit the Leprosarium at Carville, La., and see for itself just what the conditions are and why there must be a change in policy. I hope this committee will appoint a subcommittee for that purpose, because I am confident that such committee would immediately recommend passage of this bill as a means of beginning a real program.

The eminent medical specialists who have testified on this bill are in agreement that it is necessary and just. The greatest epidermiologists today say that leprosy (Hansen's disease) can be arrested, and most deny emphatically that it is necessary to virtually incarcerate everyone, as is done by the Federal Government through confinement at Carville—and that the disease can be treated effectively in many cases right in the home States and cities.

I insist, Mr. Chairman, that since we are projecting an international program that stresses freedom for all individuals of all races that we should not deny that "freedom" to our own people, especially when it is conclusively shown that such isolation as they are now subjected to is unjust and unnecessary, if not, in fact, positively un-American in its aspects of confinement and deprivation of liberty.

This is a very brief statement, but I am sincere in urging that you approve this bill and getting a definite and more beneficial program for those afflicted by Hansen's disease under way.

Mr. Priest. Our next witness is Mr. B. L. Spann, of Louisiana.

STATEMENT OF B. L. SPANN, AMERICAN LEGION, BATON ROUGE, LA.

Mr. Spann. My name is B. L. Spann, and I am from Baton Rouge, La., representing the patients of Carville on behalf of the American Legion.

Mr. Chairman, 25 years ago when we discovered Carville, at that time it was a place forgotten by man and only known to God. When we went down there our first impression was that the people had been neglected for so many years that we made it a point that we were going to do something about it. With the help of everyone, and you gentlemen in Congress, we have made rapid strides in Carville. Today it is a different place compared to what it was 25 years ago. The light is beginning to shine and the people are taking new hopes.

There used to be a time where if I came in here and told you I was a patient of leprosy, cold sweat would have come to your brows. If I had been an authority and told you that you had leprosy you would have been a hospital case. Your dread of it was so great that you would not have known in what manner to take it.

However, the strides of medical research today have brought hope to the people of Carville and whereby, through education, the little that we have been able to put forward, you better understand and know what leprosy is.

At times these people in the vicinity there were even afraid to go to Carville. When we first organized entertainment to take to those people, lots of them would say in horror that they would not go there and they would talk to their doctors. Thank God the doctors had the right attitude, and advised them to go.

We have made so many good strides and we are beginning to think of the dawn of a new era for Carville. With this bill now up before

Congress, you gentlemen now have the power and the privilege to give to those people that light.

They need it, they are the bravest people on earth, I think. I number them as my dearest friends and I know all of them and I feel that with the thing set up in this new bill that with your help we can do a lot.

I might say that if you had 400,000 people in the United States concerned in this matter, there would be so much pressure on you to do something to check the disease that you would not be able to sleep at night. A lot of people think that because of the few that are here, why worry about the few. I think that one person has much right to peace and liberty and the pursuit of happiness as thousands have. I think those people are entitled to every consideration that we can give them.

Today down in Carville, I can visualize from the picture hanging back of you gentlemen, a peaceful city and it is Carville and this is giving them a ray of hope that you are going to do something to help them.

In this bill it gives them a national advisory council. The Public Health Service is going to tell you that they have had an Advisory Council. They did have but did it function? We say no. The Council was not of the type that we need down there. We need a Council of the type that is going to function and let you people in Congress know the things that we know and what the patients know. Instead of a group that will go down to be entertained, we want a Council that will listen to the patients who after all are the ones that we are interested in.

It can go so far that it will mean in a few years the light of hope will come to all of the people.

The next thing that you need in there is your compensation. Suppose today that any one of us, and I know not of what you possess in the world, but I could take my case. Suppose I was told that I had leprosy when I arrived home. It would mean that I would be taken from my family, it would mean that shortly my home would have to be sold. Thank God that all of my children are nearly at the age where they can take care of themselves.

However, that is not always the case and they need something to live on. Place yourselves in their position. When they go in there they do not know where one dollar is coming from. The patients canteen operates there and they pay $1 a month to the blind. That is the extent of their worldly goods. The others get nothing unless people on the outside give it to them.

There are so many things that could be done that it would take hours to tell. I would be most happy some day to tell the Carville story in the way that I have seen it in my 25 years. Time does not permit that but I can only say to you gentlemen that this bill as I see it is the greatest piece of legislation that has ever been drawn. Do not let anyone, please, change your attitude toward it. The small amount of money involved will give a rare hope to those people and perhaps save thousands of people from going through what they have gone through.

I can tell you that I know Carville, I have worked with them for years and I can tell you stories that would tear your hearts out. I was down there one day and a boy wanted to talk to his mother who was dying and the restrictions were so great that they would not let him cross the hedge to say "hello" to his dying mother who was waiting there. I went back to Baton Rouge and discussed it with the Governor and the Governor called the district manager and told him that he wanted to have a phone put into Carville.

The manager said, "Who is going to pay for it?" The Governor said, "You are."

They screamed bloody murder. The Governor said, "You do not want to pay for it?" The manager said, "That is something we will not do." The Governor said, "Put the phone in and we will pay for it, but you will pay for it in the long run."

The next day the manager informed him that they had the permission to put it in and if we could get the permission from the MOC, that they would have the phone.

Those are the things that are heart rending and those are the things that exist. What are we going to do about helping them? We are giving them everything we can for medicine and thank God for the man they have there today, Dr. Johansen. For the first time it seems that they are taking care of Carville. If it continues, which it will under Johansen, you will see things that we never expected.

We need your help; they want to live a normal life, as Mr. Farrell has told you and as Mr. Strachan has told you, from the physical-handicapped side. They want to earn their own living and do something for themselves. They are not able to do so at the present time. I could tell you of innumerable cases of where they tried to do something and have been turned down by the general public—where they have tried to get passage to go somewhere and have been turned down.

Finally, the only solution was that we give them a station wagon that they can operate and go to their homes to visit. Those are the things that tear your heart out when you know what it is. I think that they are the bravest people in the world who have gone through all of these years without any compensation and certainly it is time that the Government give them something so that they will not be paupers and beg for charity when they get outside.

I can picture many cases of hardship and I know of them and it is certainly time for us to take some action and to bring a ray of light and hope to those people. I think we have no better demonstration than to look up there and see the words over your mural, "On earth, peace." If those people knew that they were going to have peace of mind and that they would not have to worry about their families and conditions when they got in Carville, it would be a tremendous blessing.

Suppose you were in there and you were called to take those treatments. If your mind is not in that condition, the treatment is not going to help you too much. If you had the peace of mind from knowing that the money was going to be provided by your Government so that your family would not suffer while you were away, they would be in condition to take that treatment and to feel as though everything possible was being done for them.

As a layman and as one who knows Carville, I know of no greater deed that you gentlemen of this committee could do than to recommend to Congress the full enactment of this bill and see that it is put into effect in its entirety. I think H. R. 5234 is one of the greatest pieces of legislation that you could possibly enact in your Eighty-first Congress.

Mr. PRIEST. Thank you very much, Mr. Spann.

We have been informed by our colleague, Mr. Brooks, of the very fine work that the American Legion has done in connection with the hospital at Carville.

Are there any questions?

Mr. SADOWSKI. No questions.

Mr. BROOKS. May I say this: I have known Mr. Spann for 25 years and Mr. Sam Rubin, who is here from Monroe, likewise has spent much time in the work of the American Legion and they are both working in a philanthropic manner for what they conceive, and I do, too, to be one of the greatest programs that we have in our section.

Mr. PRIEST. Thank you very much, Mr. Brooks.

Are there any other questions?

We thank you again for your appearance and for the fine work that you have been doing.

Mr. SPANN. Thank you, gentlemen.

Mr. PRIEST. Our last witness will be Mr. Harry S. Wender, who desires to summarize briefly.

STATEMENT OF HARRY S. WENDER, GENERAL COUNSEL, AMERICAN FEDERATION OF PHYSICALLY HANDICAPPED AND AMERICAN FOUNDATION FOR PHYSICALLY HANDICAPPED, WASHINGTON, D. C.

Mr. WENDER. Thank you, Mr. Chairman. I realize the hour is late and you have been very patient today, listening to the witnesses on important legislation.

I am Harry S. Wender, the general counsel of the American Federation of Physically Handicapped and the American Foundation for Physically Handicapped. I want to make it clear that I am a volunteer and I receive no compensation, and that all of the expenses of my office are taken care of by myself. I think it is only fair to say that I am under the hypnotic influence of Paul Strachan who seems to influence every person that he meets to do something worth while for humanity.

When I met him some years ago and he told me that they needed legal advice I began giving it and I have been giving it ever since. I have had the pleasure of working with him before congressional committees and in the Senate and I would like to say at this time a few words in summary and also to make some passing comments, particularly with reference to the Hansen's disease legislation which is before you.

At the outset I am sorry that Mr. Bennett is not here because it seems to me that he epitomized the whole situation before the committee with respect to these several bills. He said that there could be no question as to the need for legislation on these various dreaded disease subjects. You have heard the great experts and all of them tell you that only Congress and only the Federal Government can give the assistance that is required for the vast scientific research that will eventually untie or cut through the Gordian knots that are represented by these many diseases, whether it be arthritis, cerebral palsy, or Hansen's disease.

These have been with us for generations, centuries, for thousands of years, as a matter of fact. Only of late have we begun to solve these problems and we will never solve them adequately until we have one concentrated agency that has the primary responsibility for coordinating all that is being done throughout the country and throughout the world.

He said that and a little more briefly than I did.

So that, we acknowledge that there is this need. No one can say with any degree of reasonableness that we should not have legislation. He said also that there is no question but what needed funds, more funds, adequate funds, are required to stimulate and make possible the kind of research and the dissemination of the information that we get as a result of this research. How much money, I am not qualified to say, and I do not think anyone particularly is qualified to say just how much now.

When we set up the kind of agency that we want, then we will be in a better position to know the relative amount of money that needs to be spent.

So that we have the need for doing something and we have the need for money. The only question, it seems to me, that is before this committee and before the similar committee of the Senate is whether or not in such legislation as you may pass with respect to these various kinds of diseases you are going to blueprint, what should be done by the respective Federal agencies that will be involved or whether you are going to leave it to the discretion of the administrators to carry on as they have more or less in the past.

I think that the philosophy of the Federation whom I represent here today and of practically all of the witnesses that have appeared before this committee, and before Senator Murray's committee on the Senate side, can be put into a nutshell by saying that we all agree that there should be a blueprint. We cannot afford any longer to leave to "happen-chance" or to the individual personality or thinking of anyone, or any two or three administrators.

What should be done and how much should be spent and where this money should be spent in order to solve these various problems affecting the lives of so many of our people. It is our opinion that Congress, which after all is the agency representative of all the people, should make the determination. It should blueprint, as we say, how the agencies ought to be set up, what they are to do, who shall compose the various counseling agencies, what ought to be their responsibilities and then how this money is to be spent and how much money is to be spent. We say that is the only reasonable way to do it.

Whether or not the committee feels in its wisdom that this should be done in an omnibus bill or in the group of related bills is of little consequence to us because after all it is the same thing either way you do it.

If you have one bill and each individual disease is dealt with separately, it is practically the same thing as though you had separate bills and they were called up one after the other, as the case might be. We are not concerned with that technical characteristic of legislation. We are deeply concerned with the importance of having this committee and Congress, ultimately both Houses of Congress, knowing in advance what will be the administrative result of what you set out in this legislation so that you then will not leave it to chance and that you will be able to check up and see whether or not these various counselors and various administrative officials are doing the kind of job that you not request but that you demand be done.

It is not merely an authority but a requirement that they be carried out as you say. That is what we are talking about primarily.

We have given you the experts who have without any question, any shadow of a doubt, indicated to you the necessity for legislation. I am not going to review the splendid testimony that has already gone before you, but when such men as Dr. Lennox, the world's greatest authority on epilepsy—just think of it, you had the honor, we had the honor, of sitting with a man who knows more about that particular subject than any living person or probably more than any man who ever lived. He is not a young man but he still has many years ahead of him and we want to use him to the best of our ability.

When we recognize the hundreds of thousands of epileptics in the United States and how much this man knows, that we can transmit and yet there are ignorant doctors in the United States who will not accept his advice.

I learned of Dr. Lennox where a little country doctor, undoubtedly a fine man, but this gentleman was giving some kind of drug to a patient in West Virginia, a girl who incidentally is a member of our organization. She wrote to Dr. Lennox and Dr. Lennox suggested one of the drugs that he mentioned to you today as a treatment. This doctor who was completely ignorant of epilepsy, of its consequences, of its treatment, or anything else, said, "No."

We have a lot of educating to do, gentlemen. We have to educate the doctors as well as the public. We have to educate the doctors in the kind of treatment, in the kind of psychological approach to these people and other phases as well. You heard young Nick Farrell and that is not his name, talk to you today.

You are the first committee of the House of Representatives that ever listened to a known victim of Hansen's disease. This was a historic moment when that man appeared before you because nobody ever had the courage before to say, "I was what has been known as a leper." No man had the courage to do it because he knew that when he walked away, under ordinary circumstances others would walk away from him. He made a most dramatic and most inspiring presentation to you and he had the courage to tell you of his life history.

We hope that a lot of good will come from that not only from this committee, but that perhaps he can be used to serve as a symbol to people of his kind all over the world and believe me there are some 10,000,000 victims of Hansen's disease all over the world.

I think you would be interested to know that Sam Rubin, my good friend from Monroe, La., said that from Carville they sent the drugs to Jerusalem, the ancient home of leprosy, spoken of in the Bible and some 20 victims of leprosy have been cured in the hospital in Jerusalem as a result of the research that our engineers and chemists in our country have brought about. We are going to cure people all over the world with what we can do here. You will be doing not only a great thing that is a great blessing for humanity among our citizens of the United States, but of the countless millions of people all over the world who are afflicted and who do not have a Congress and who do not have a government and who do not have the specialists and scientists.

We need the research and we need the funds so that young men can go into research because they cannot afford to do it today. The cost of medical training is so great that when they have accomplished their medical training today, they cannot afford to work as medical technicians when they have their medical degree and can go into practice and can make good money after the years of study and years of work that they have put into the medical profession.

I would like to parenthetically state that I have been so inspired today that when I speak at the National Recreation Congress in New Orleans, La., in September—I am chairman of the recreation board for the District of Columbia and I have been invited to speak at the convention there—I intend to visit Carville which is some 80 miles away from New Orleans. I want to go down there and see these things myself, not because of anything I can do to influence this committee because I sincerely hope that before September this committee will have disposed of this legislation, but because I want to satisfy myself as to some of the conflicting statements I have heard made by representatives of the Public Health Service on the one hand and men like Mr. Farrell who have actually been residents of Carville.

So, we leave this legislation with this committee with the full hope that you will recognize that you have before you probably the most significant legislation that any session of Congress has ever handled for the welfare of mankind.

I thank you, gentlemen.

Mr. PRIEST. Thank you so much for a very fine statement. We appreciate what you have had to say.

Are there any questions?

Mr. SADOWSKI. No questions.

Mr. PRIEST. Thank you again.

Without objection, at this point in the record there will be included a statement by our colleague, Mr. Hand, who has introduced a bill, H. R. 3929 on another subject. It was included in the program for today.

(The statement is as follows:)

HOUSE OF REPRESENTATIVES,
Washington, D. C., June 22, 1949.

Hon. J. PERCY PRIEST,
Chairman of Health Subcommittee,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: In response to your kind invitation to make a statement on my bill H. R. 3929, now pending before your committee, I am enclosing one, and would appreciate your including it in the record at an appropriate point.

Sincerely,

T. MILLET HAND, M. C.

Mr. Chairman, I appreciate the invitation of the committee to present my views in connection with the committee's hearings on various bills providing for medical research and for improvement to the national health.

I have observed that the committee has listed my bill H. R. 3929, as a bill providing for research with respect to cancer, heart disease, and poliomyelitis. This is accurately extracted from the title of the bill, but the truth is that the purpose of my bill is to establish a general agency of Government to be known as the Medical Research Agency.

The bill authorizes the Agency to initiate, conduct and support scientific research with respect to the cause and cure of cancer, rheumatic fever, Bright's disease, diabetes, diseases of the heart and circulation, and other major diseases of mankind, and in addition directs the Agency to investigate the cause and spread of contagious or infectious diseases, including malaria, and to make recommendations with respect thereto.

I emphasize the general character of the bill because I see no logic in the Congress setting up a Federal agency for strictly limited health purposes, no matter how important. Various members have emphasized arthritis, rheumatism, multiple sclerosis, epilepsy and other major illnesses. If we're to deal with this problem logically, what we need is a general research agency which will concern itself with all of the many important attacks on the public health; not only, Mr. Chairman, the great killers, such as cancer, and the cardiac disturbances, but even such widespread, although minor menaces to the public health and productivity, such as the common cold.

It is my view that the Federal Government, within the scope of its proper functions, can best improve the public health by a coordination of, and assistance to general medical research. Thus section 5, of the bill provides that the agency may enter into contracts for this purpose and acquire suitable buildings for scientific investigation and the need for equipment; and to receive and use funds donated by others and to correlate both public and private medical, scientific and technical information. The bill authorizes the appropriation of $5,000,000, and such appropriations as shall thereafter be made by the Congress.

I pretend to no expert knowledge in the field of medicine or field of public health, but I am persuaded that an honestly administered Federal Agency serving not as an exclusive and all-powerful bureaucracy, but serving to coordinate and assist the enormous body of knowledge research and study now being conducted throughout the country could, for a comparatively modest sum, make an outstanding contribution in the course of time to scientific and medical knowledge, and to the public health and welfare.

It is my present belief that this is the proper field of the Federal Government in regard to these problems.

I know that the committee is deeply interested in the many bills that are before it. I have no thought or desire that my bill should be selected and reported. I merely want to emphasize that there is need for a Federal research agency of this general character, and that the scope of our research should be in no wise limited to one or more specific diseases, but should study them all.

Mr. Priest. The committee will stand adjourned until 10 o'clock tomorrow morning.

(Thereupon, at 4:10 p. m., the committee recessed to reconvene at 10 a. m., June 24, 1949.)

NATIONAL HEALTH PLAN

FRIDAY, JUNE 24, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334 New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee), presiding.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills)—national health, with respect to Title II—Medical Research.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills)—national health.

H. R. 4874, by Mr. Miller of Nebraska—for the establishment of the Medical Care Investigation Commission.

House Concurrent Resolution 29, by Mr. Beall—providing for expansion and intensification of public-health research on the family aspects of chronic illnesses.

House Joint Resolution 7, by Mr. Bartlett—authorizing an appropriation for construction of buildings and facilities in or near the University of Alaska for research in Arctic health.

H. R. 4840, by Mr. Fogarty—to provide for a survey of sickness in the United States.

Mr. Priest. The committee will come to order.

The hearings today are on some bills somewhat related to title II of the omnibus bill. Title II provides for medical research. The bills today are not included in title II of the omnibus bill, but since they also deal with research in one form or another, they are closely related, and it was the decision of the committee to hold these hearings at the end of hearings on title II of H. R. 4313 and H. R. 4312.

We have for first consideration this morning, House Concurrent Resolution 29, introduced by the Honorable J. Glenn Beall, of Maryland.

We are very happy to have Mr. Beall come forward at this time, and without objection, there will be included in the record the report of the Federal Security Agency on this bill; and for the members of the committee a copy of that report along with other reports of the agency has been compiled.

(The report above referred to is as follows:)

Federal Security Agency,
Washington, June 14, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Chairman: This letter is in response to your request of February 11, 1949, for a report on House Concurrent Resolution 29 which states that it is "the sense of the Congress that research on the familiar aspects of chronic disease and investigations of practical methods of furnishing family health services should be expanded and intensified, and that the United States Public Health Service should extend its activities toward this end."

The resolution draws attention to the importance of the family as a unit in relation to health and disease, and to the studies which the Public Health Service has conducted for a number of years in Hagerstown, Washington County, Md., in cooperation with the county health department, the county medical society and other private and public agencies.

This resolution reemphasizes the need for intensifying investigations on the family factors in chronic disease. Much of the success already achieved in controlling, and in some instances virtually eradicating infectious diseases such as typhoid fever, tuberculosis and diphtheria, stems from knowledge gained through investigations on family and environment—leading to a more precise understanding of the patterns in which these diseases spread and laying a foundation for the prevention of transmissible infections. To control chronic diseases, a similar approach is needed to supplement findings from laboratory and clinical investigations.

Study of the effects of family factors upon the incidence of disease was begun by the Public Health Service in Hagerstown and Washington County in 1921. Ten years ago, the current program of long-term family studies was initiated. At that time, a systematic organization of data from past and current special studies was begun and integrated with all information on the town and county population available from public and private agencies. These studies have been carried on through the local health department, with the enthusiastic support of the medical and dental professions, the county hospital, school authorities, industrial firms, and by virtually all of the private agencies in the community.

The need for expanding the work at Hagerstown to provide a sound base for the study of family health problems, and particularly the problems of chronic illness, has long been recognized. As the proposed resolution implicitly recognizes, there is no lack of basic authority in existing law to carry on the work which the resolution would emphasize. In fact, the efforts of the Public Health Service, the Washington County Health Department, and the Washington County Medical Society toward this end have been limited only by lack of funds. The Public Health Service's participation has been financed entirely out of the general appropriation of the Division of Public Health Methods.

The Division already has formulated plans which could be used as guide lines in such development. These plans embrace the establishment of research centers in which studies on various aspects of family health programs would be conducted, as well as of consultant service to assist health and medical authorities in the development of research and demonstrations.

In view of the other essential activities of the Public Health Service which depend on the limited funds at our disposal, the carrying out of these plans, however, would call for additional appropriations.

We are advised by the Bureau of the Budget that it has no objection to the presentation of this report to your committee, but that it is of the opinion hat this subject more appropriately is one for consideration in connection with the preparation of the annual budget.

Sincerely yours,

J. Donald Kingsley, *Acting Administrator.*

STATEMENT OF HON. J. GLENN BEALL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

Mr. Priest. Mr. Beall, you may proceed.

Mr. Beall. Mr. Chairman and members of the committee, I want to thank you for the opportunity of being here this morning because, feeling as I do, the necessity for expanding the present functions of the Division of Public Health Methods to include increased study of the health problems of the family as a unit, I introduced House Concurrent Resolution 29 in this Congress.

Such a study has been in progress in Washington County, Md., under the supervision of Dr. P. F. Prather, deputy health officer of the

State of Maryland, and county health officer for Washington County, Md., I should like to include in my remarks the statement of the United States Public Health Service regarding the studies being carried on in Hagerstown and which we are so anxious to have expanded. I believe this statement covers the matter thoroughly.

(The statement referred to above is as follows:)

STATEMENT OF THE ACTING SURGEON GENERAL OF THE UNITED STATES PUBLIC HEALTH SERVICE RE THE HAGERSTOWN STUDIES (SUBJECT: REPORT ON H. CON. RES. 29)

House Concurrent Resolution 29 declares that the Public Health Service should extend its activities toward expanding and intensifying (*a*) research on the familiar aspects of chronic illness, and (*b*) investigation of practical methods for furnishing family health services.

The resolution draws attention to the importance of the family as a unit in relation to health and disease, and to the studies which the Public Health Service has conducted for a number of years in Hagerstown, Washington County, Md., in cooperation with the county health department, the county medical society, and other private and public agencies.

This resolution reemphasizes the need for intensifying investigations on the family factors in chronic disease as formally presented in the resolution unanimously adopted by the Washington County Medical Society, September 13, 1947.

Much of the success already achieved in controlling, and in some instances virtually eradicating, infectious diseases such as typhoid fever, tuberculosis, and diphtheria stems from knowledge gained through investigations on family and environment—leading to a more precise understanding of the patterns in which these diseases spread and laying a foundation for the prevention of transmissible infections.

For most chronic disorders, no specific causative factor has been discovered; and for many, there may not be a single factor. Whatever factors are responsible may be in action for weeks, months, or years before symptoms become manifest. Their effects are conditioned by the individual's inherited constitution and his living and working environment. Moreover, the long duration of these disorders has financial repercussions on the individual, his family, and his community, thus making economic and social considerations intrinsic to the control of the disorder.

The Public Health Service heartily approves the purpose of House Concurrent Resolution 29. In fact, the efforts of the Public Health Service, the Washington County Health Department, and the Washington County Medical Society toward this end have been limited only by lack of funds. The Public Health Service's participation has been financed entirely out of the general appropriation of the Division of Public Health Methods.

The Division already has formulated proposals which could be used as guide lines in such development. These proposals embrace the establishment of research centers in which studies on various aspects of family health problems would be conducted, as well as of consultant service to assist health and medical authorities in the development of research and demonstrations.

Now, Mr. Chairman, my intention and desire is not to take up the time of the committee, and I am not going to go into the details of this resolution, in order to avoid repetition, and if I may, I am going to ask Dr. Prather to come up and make a statement as to why this bill is necessary, and then I would like to have Dr. Poole, secretary of the Washington County Medical Society, make a statement, and Mr. Perrott, of the United States Public Health Service, and Dr. Ciocco of the United States Public Health Service.

If I may, Mr. Chairman, without any further remarks of my own, I am going to ask that Dr. Prather be heard.

Mr. PRIEST. Very well, Mr. Beall, we will be very happy to have Dr. Prather as the next witness.

STATEMENT OF DR. PERRY F. PRATHER, DEPUTY HEALTH OFFICER FOR THE STATE OF MARYLAND, AND COUNTY HEALTH OFFICER FOR WASHINGTON COUNTY, MD., HAGERSTOWN, MD.

Mr. PRIEST. Dr. Prather, will you give us your full name and official position?

Dr. PRATHER. Perry F. Prather, deputy health officer for the State of Maryland and county health officer for Washington County, Hagerstown, Md.

Mr. PRIEST. Very well, Doctor, you may proceed.

Dr. PRATHER. I have a prepared statement and I have done that in order to conserve your time, and I believe you have in your hands or there has been given to the members of the committee copies of the plan. I have five copies here of my statement.

MAGNITUDE OF THE PROBLEM

One of the biggest problems confronting our Nation today is the care of the chronically ill. The Federal Government, States, and smaller communities are being called upon to spend vast sums of money for institutions and services to meet the problem. Up to now emphasis has been placed on providing institutional care for advanced stages of disease. A new orientation should place major emphasis on the early stages of chronic illnesses with a view to preventing or at least delaying the progress of the disease process. The problem is a rapidly growing one because of the increased life expectancy.

The problem can very well be divided into four major phases: The research phase, the preventive phase, the treatment phase, and the rehabilitation phase, and we feel that the research phase is very important and should be in proper balance.

INTELLIGENT PLANNING MUST BE BASED ON SOUND RESEARCH

Quotations from a joint statement by the American Hospital Association, the American Public Welfare Association, the American Public Health Association, and the American Medical Association, regarding research in the field of chronic diseases are as follows:

> Further advances in the prevention as well as the treatment of many chronic diseases are dependent on research. Although a good deal of research is now being carried on in chronic disease, only a fraction of the total need is being met.
>
> War experience in medical research has made it clear that we must broaden our vision and think in terms of research planned and organized on a much larger scale than any now contemplated. This requires the training and support of a much larger corps of medical scientists and the development of teams of research workers to carry forward coordinated programs. The greatest emphasis must be placed on those diseases which are the most important causes of death and disability, such as heart disease, high blood pressure, arteriosclerosis, arthritis, kidney diseases, cancer, diabetes, and asthma.
>
> There is a great need for administrative research, for more precise information on methods of providing the necessary services for the chronically ill. Basic research on some of the administrative problems is already being undertaken, but the field is a relatively new one and requires intensive study and development.
>
> Research is necessary also in the social and psychologic aspects of chronic illness. The influence of these factors in development of specific chronic diseases needs to be more fully determined, while the effect of chronic illness on the individual's social relationships needs further study.

AN APPROACH TO THE PROBLEM BY STUDYING THE FAMILY ASPECTS OF CHRONIC ILLNESSES

For some time the medical profession has known that one cannot properly evaluate or treat an individual organ of the body. In heart disease, for example, in order to make a correct diagnosis, to plan and carry out proper treatment for this disease, consideration must be given to the patient's weight, blood pressure, kidney function, temperament, et cetera. The same consideration must be given when one is confronted with a disease of any other organ of the body.

The medical profession now knows that a sick individual must be looked at as part of a family which is at the same time a social and biological unit. The individual shares the same environment, eats the same food, is influenced by the same emotional situations, and has the same inherited characteristics.

The patient does not exist by himself, but as a member of the family unit as traditionally implied in the term "family doctor."

Each family has its own pattern and it is different just as individuals are different.

We should have methods by which to study and treat families that have a sick member just as we study and treat individuals that have a diseased organ.

HISTORY OF THE HAGERSTOWN STUDIES

In 1921, Hagerstown was selected as a cross section, stable community in which to conduct morbidity and mortality studies. These studies have been going on in a more or less uninterrupted and limited way to the present date. An accompanying list of publications based on Hagerstown data has to do with public health and welfare problems. These studies have had wide publicity and have had considerable influence on teachers, administrators, and technicians in their thinking, planning, and administration of public-health programs.

In 1925, 4 years after these studies began, I came to Hagerstown to practice medicine and for 24 years—19 as a practicing physician and 5 as a public-health administrator—have had the privilege of seeing at close hand the development of these studies and I am convinced of the need for the continued and expanded efforts as contemplated by the United States Public Health Service.

THE CHOICE OF HAGERSTOWN AS THE MAJOR CENTER FOR RESEARCH IS BASED ON THE FOLLOWING CONSIDERATIONS

(*a*) Considerable knowledge of morbidity and mortality in the Hagerstown population, accumulated since the first study made there in 1921, supplies the nucleus of background information on several thousands of families. Hagerstown, where conditions are considered fairly typical of American life, has a relatively stable population, which is a decided advantage for long-term studies.

(*b*) The medical and dental professions, the health authorities, industrial and civic groups, and the population itself have cooperated in former Hagerstown health studies. The necessary cooperation so essential to long-term studies would take years to develop in another community.

(*c*) Proximity to institutions, such as the University of Maryland, Johns Hopkins, and Washington, which will furnish consultant services and observe the programs of the study.

(*d*) Considerable contributions to the studies by local official and volunteer agencies.

A close study of the various public-health activities conducted in Hagerstown, Washington County, will revealed that there already exists a good working relationship between all the health agencies, including Federal, State, and local, both official and volunteer.

A FIELD LABORATORY IN REALITY

A large group of families kept under observation continuously or intermittently over considerable time. When one speaks of research there comes to mind immediately a laboratory, test tubes, and animals; and this is what usually makes the headlines. Field research, that is. the observation of human beings and their reactions, is just as important and useful.

CREATES NO OVERLAPPING

Emphasis to be placed on chronic diseases for which no Government research programs have been undertaken. For other diseases the center will carry on its studies in cooperation with the appropriate units of the United States Public Health Service engaged in research or control programs.

LONG-TERM STUDY NEEDED TO FIND THE SOLUTION TO CAUSES OF CHRONIC ILLNESSES

Research in the past has been largely confined to study of short-term (acute) illnesses such as diphtheria, typhoid fever, lockjaw, pneumonia, and other infectious diseases and many of them have been virtually eliminated. In order to make any headway with the chronic diseases they must be studied over long periods. Every possible influence, for example, diet, environment, and heredity, must be considered.

PRACTICAL IMPORTANCE OF STUDIES TO HEALTH ADMINISTRATORS AND PHYSICIANS

1. If one studies the list of publications that have come from the Hagerstown data it will be noted that many of them were what we call surveys, that is, a determination of the amount and kind of illnesses that exist in certain groups, such as school groups, age groups, sex groups, economic groups, racial groups, et cetera. This is of the utmost practical importance.

A public-health administrator needs to know the extent and nature of a problem he is called upon to cope with just as much as a business executive needs to know the facts regarding population, amount of employment, and per capita income in a community where he plans a venture.

2. One special study conducted in Hagerstown having to do with child health and the selective-service physical standards (No. 64 on the list of publications) was considered of sufficient importance to

warrant hearings before a subcommittee of the Committee on Education and Labor of the United States Senate, second session, Seventy-eighth Congress.

3. Other surveys in Hagerstown having to do with dental caries, tuberculosis, heart disease, cancer, malnutrition, undulant fever, and typhoid carriers have uncovered unknown cases who were able to seek early treatment and thereby avoid the disabilities that would have developed if they had gone undetected.

The techniques of uncovering the cases were published and individuals in other communities have benefited.

4. Physicians and their patients are benefited in a practical way when it is shown that certain diseases tend to be more frequent in certain families. The physician is a better counselor when he knows what to anticipate, and he can also advise and plan more wisely for his patients when environmental influences are found to be associated with disease processes.

As the result of the studies in Hagerstown communities, special studies have been followed such as the prevention of deafness program, and various other programs have been developed, and as a result of these studies the clinics have been visited by physicians from all over the country.

Thank you, gentlemen.

Mr. PRIEST. We thank you for your statement.

The effect of this resolution, if passed, simply would be an expression that it was the sense of Congress that the Public Health Service should expand this work in this field.

If the Public Health Service followed in line with the suggestions and with the expressions of Congress, it would require, of course, additional appropriations.

I wonder if you have any estimate as to what additional appropriations might be necessary, assuming that the resolution passes and the Public Health Service proceeded then to follow and adopt a program in line with the resolution.

Mr. BEALL. Mr. Chairman, may I interrupt and answer that question, if I may?

Mr. PRIEST. Very well.

Mr. BEALL. I would like to say, sir, it is not our intention to ask for any money at this session of Congress. We would like to get the resolution in order that they may, in the interim, study it and then come in here next year, through the Department of Public Health and ask for money and then submit at that time the costs if they have any of them available; but we want to bring it out in order that the Public Health Service may study it. That is really the intention of this resolution. It is in order to save time.

Mr. PRIEST. Just a second, Doctor, there may be some other questions that some members of the committee would like to ask.

Mr. BENNETT. Yes, Mr. Chairman, I would like to ask Dr. Prather some questions.

Mr. PRIEST. Mr. Bennett.

Mr. BENNETT. How will this kind of a program work out as a practical matter? How would you go about it?

Dr. PRATHER. How would you set up such a program?

Mr. BENNETT. Yes.

Dr. PRATHER. Well, sir, we have a program now. We have a young doctor, a Ph. D. who handles the statistics. He has a couple of helpers and the program is going on in quite a limited way. An organization to conduct such studies would be composed largely of those people who are trained in genetics, those people who are trained as medical statisticians, with their clerks and their helpers. It would be largely a personnel group to mull over and analyze and get the most out of the records, and that is why I think it is right important.

There is one point that I made——

Mr. BENNETT. Would this organization that you set up study the statistics that are available, or would they go out and make new investigations?

Dr. PRATHER. Both. It is proposed that they do both. The investigators would trace back through family histories.

Let me give you an example of what type of work we are doing. Maybe this will best explain it. That is an unpublished work and I do not want this to get into the newspapers, because any time a doctor says——

(After informal discussion off the record.)

Mr. BENNETT. How broad would you make it; would you set up research units in every State or would you set them up in a number of cities throughout the country?

Dr. PRATHER. Well, the plan is to set it up in Hagerstown, because we have there a great volume of accumulated records, greater volume than any other community in the country.

I have literally thousands and thousands and thousands of records that have been accumulated regarding families. If we do not do anything else but just study those records alone, a number of men could be kept busy digging out some valuable information from the records we already have; and it is true, it is proposed that perhaps maybe some of the studies made later on like set-ups elsewhere would be coordinated and tied in with what we are doing; but the thing they are deeply interested in now is starting this thing in Hagerstown.

Mr. BENNETT. I just want to get an idea of how extensive it would be; how practically the matter would be carried out; whether you would go into each State and set up the type of research used, or whether you would set it up in connection with each study.

Dr. PRATHER. No, sir; it would be in a sense a laboratory, because the community is a fairly typical community; not too far north; not too far south; no preponderance of foreign born there. It is partly industrial, partly industrialized, and the industries are diversified; the farm industry is diversified.

I mean, it was selected in 1921 as a typical, average, stable American community, and for that reason it is a cross section and the greatest part of the work that has been conducted in that community has been because it is a cross section.

Mr. BENNETT. Under these bills before the committee to establish health research institutes in various diseases, would it be your idea that the institute, for example, a set-up to do research in epilepsy would carry on the type of family work which is contemplated by this particular bill?

Dr. PRATHER. It is our aim and I think it can be worked out; I am absolutely sure, anywhere where research is being carried on in particular diseases, such as epilepsy, there would be no duplicate approach of what we are after, and they could come to us for the family aspect of the particular problem.

Mr. Bennett. In other words, you would set up a special unit on family research for each special unit set up?

Dr. Prather. No. We would be interested in a consulting way with the institutes that are already interested in the particular disease, and furnish them with the family aspects of the family approach to the problem. Other researches or organizations or institutes which are asked to be set up are based upon laboratory data or clinical studies and hospitals, and that type of research, and we would hope to tie in with any particular research problem by furnishing the necessary information regarding this aspect of the disease.

Mr. Priest. Are there any further questions? Thank you, Dr. Prather.

Dr. Prather. Thank you.

Mr. Beall. Mr. Chairman, I would like to present Dr. Perrott of the United States Public Health Service, and Dr. Ciocco, professor of biostatistics, school of public health, University of Pittsburgh.

Mr. Chairman, I would like for Dr. Perrott to make a statement and also for Dr. Ciocco to make any statement he cares to make.

Mr. Priest. Very well, we will be pleased to have their statements. Will you please identify yourselves for the record.

STATEMENTS OF DR. GEORGE S. PERROTT, UNITED STATES PUBLIC HEALTH SERVICE, WASHINGTON, D. C.; AND DR. ANTONIO CIOCCO, PROFESSOR OF BIOSTATISTICS, SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF PITTSBURGH, PITTSBURGH, PA.

Dr. Perrott. My name is George S. Perrott, and this is Dr. A. Ciocco.

I am in charge of the Division of Public Health Methods in the United States Public Health Service, in charge of the division in which the Hagerstown project is located.

Dr. Ciocco is now with the school of public health, University of Pittsburgh, but for 10 years was in charge of the Hagerstown project and is familiar with all of the retails of that project and can answer and detailed questions the committee may wish to ask.

I have no prepared statement, Mr. Chairman.

The agency has submitted a report, as you stated earlier. I simply want to say briefly that in summarizing, the Agency report, that the Agency feels that these activities should be expanded and that this is a tremendously important activity.

We feel that in this country and in the Public Health Service there is a great deal of research going on in and among animals in laboratories. There is a good deal of clinical research on sick people, and in hospitals, but we have had only a small amount of study of the average man in his average community, and it is the sort of studies that we are making in Hagerstown, family studies, of the health of the average people that the Public Health Service feels should be expanded.

I might be of interest to the committee to know that at the recent meeting of the recently formed Commission on Chronic Diseases in

Chicago—and parenthetically the Commission on Chronic Diseases is a voluntary organization consisting of lay and professional people which has just been formed, to consider the whole question of adequate care of the chronic sick.

But at that meeting, one of the types of research which it felt was tremendously necessary was the study of illness among people in the average community; the study of what might be done about that illness in the way of prevention and cure, and a consideration of what was needed in the way of personnel and facilities to do the job, which is the type of information we have in Hagerstown, the type of community we think that type of study might be made in.

So that I simply want to say again, the Public Health Service feels that it would be very desirable to expand these studies.

Mr. Priest. Are there any questions?

Mr. Bennett. Mr. Chairman.

Mr. Priest. Mr. Bennett.

Mr. Bennett. How far would you expand them, Doctor, and in what way?

Dr. Perrott. In terms of what we would do?

Mr. Bennett. Yes.

Dr. Perrott. Well, I think that the committee—I believe that Dr. Prather submitted to the committee a memorandum on the Hagerstown project and some of the types of investigations that we think we need expansion on.

I would like to have Dr. Ciocco comment on that point, since he has given perhaps more thought to it than any of us.

Dr. Ciocco. Mr. Chairman.

Mr. Priest. Will you give your full name for the record.

Dr. Ciocco. Antonio Ciocco, professor of biostatistics, at the school of public health, University of Pittsburgh.

There are several problems connected with this family study. One of them is to determine how do you go about doing such things, that is, the methodological aspect of the study which has interested us particularly in these first years.

The second point is to determine precisely, what are the conditions that you can calculate.

Dr. Prather has mentioned that it is particularly important from the standpoint of the physician and of the public health officer to know what are the family conditions.

Now, the point is, when you see disease running in a family, as I say, that does not mean anything. It can be a variety of things. It can mean that there is, say, infection or that it is transmitted from one member of the family to another. It may mean they have a genetic condition, or as they say, have inherited something, or it may mean that they are just living under common conditions which produce this particular disease.

Now, there is the second point which is very important and which must be studied.

A third aspect is the practical approach which the health officer or a physician can make to tackling the problem of the family as a whole, and that, of course, in Hagerstown, with the cooperation of the local medical society and local health department, has been done, and the idea has been that the unit there can follow up on all of these activities that affect the family as a whole and find out how much it will cost, and find out how many are involved, and what the benefits will be which would come out of it.

Mr. Bennett. Well, the thing that I am interested in mainly is this: I am trying to reconcile the work the several institutes, which it is proposed, be set up for separate diseases will do with the studies you propose here. It seems to me—I know nothing about this business—but it seems to me that if you are doing research in cancer and set up a special institute to do that kind of work that what you are talking about—and I think it is very important—but it seems that kind of work would be carried on under the direction and by the staff that handles the work of the Cancer Research Institute set up within the Public Health Service.

Dr. Ciocco. That is the way it actually operates, in a sense. We cut across all these categories, all these diseases, and for those diseases for which there is set up already an institute, the experts and the people and the ideas—for example, one studying cancer would be in continuous consultation with or get the assistance from the cancer unit and similarly heart or, in the past, for example, the relation to dental studies that have been done; the tuberculosis studies that have been done there. They will use the talents and knowledge and experience of these institutes, but you see, their interest is in one particular phase and in one particular disease. Here we are trying to cut across, looking at the family as a whole, and ascertain whether there is any relation which may occur between the various diseases.

Mr. Bennett. Yes, my point is, if you are making a study of epilepsy, for example, that you would, in looking at epilepsy, you would study families that had epilepsy, would you not? I mean, is not that a part of the integral research you would do on the general subject?

Dr. Perrott. We could perhaps liken this to a laboratory. This is a sort of a human laboratory. And, really what we have in mind there is in a way, machinery, and facilities of a human laboratory. For example, in Hagerstown now, we have records on almost grandfathers' health records, I think, when they were children, and it is the keeping up of that sort of information on the whole population, and having our staff do that that consists of your laboratory. That is an average community. And it seems to us that the way, then, to study a specific disease and the environmental effects on the population, that you need this sort of human laboratory, as I have called it, set up and then the Institute for Cancer or some of the other specific diseases, has the facilities developed in that place, which they could not invent over night, really. It is a thing that has gone on for many years, and it seems to us should be continued.

Mr. Bennett. But do you think there is necessity for special legislation to carry on work of this kind if Congress passes a bill to set up these various health institutes? In other words, I am trying to find out, is this not something to be carried out in connection with the research work of the particular institutes.

Dr. Perrott. You do not need special legislation to carry on this work, sir.

Mr. Bennett. Thank you.

Mr. Priest. Are there any further questions? Doctor, how long has the study at Hagerstown been in progress?

Dr. PERROTT. Since about 1921, I believe. Is that not correct, Dr. Prather?

Dr. PRATHER. Yes.

Mr. PRIEST. That is longer than I realized.

If there are no further questions, we thank you very much for your statement, Doctor.

Dr. PERROTT. Thank you.

Dr. CIOCCI. Thank you.

Mr. PRIEST. Is Dr. Poole present?

Dr. POOLE. Yes, sir, Mr. Chairman.

Mr. PRIEST. Doctor, will you give your full name and identification for the record?

STATEMENT OF DR. ERNEST F. POOLE, SECRETARY, WASHINGTON COUNTY MEDICAL SOCIETY, HAGERSTOWN, MD.

Dr. POOLE. Dr. Ernest F. Poole, secretary of the Washington County Medical Society, Hagerstown, Md.

I just have a few words to say, and I would like to submit that written statement.

(The statement referred to is as follows:)

WASHINGTON COUNTY MEDICAL SOCIETY,
Hagerstown, Md., September 15, 1947.

UNITED STATES PUBLIC HEALTH SERVICE,
DIVISION OF PUBLIC HEALTH METHODS,
Bethesda, Md.

DEAR SIRS: At the regular meeting of the Washington County Medical Society on September 13, 1947, the following resolution was adopted:

"For a number of years the United States Public Health Service has cooperated effectively with the Washington County Health Department in studying many aspects of the health of the community. As a result of this cooperative endeavor new significant approaches have been made toward the study of health problems and investigations of the major factors involved. A considerable volume of information has been accumulated concerning the health of the people, the composition of the population, and the composition of family groups. This information becomes increasingly valuable as time progresses, and offers the basic material necessary for the solution of many more problems of practical importance. Since this community was originally selected for study because it is a fairly typical small city, studies conducted here are of value in their applicability to the county as a whole.

"The broadening of the scope of public-health activities by such programs as indigent medical care, cancer clinics, rheumatic-fever control, etc., offers possibilities of promoting a new type of integrated action by the medical profession and the health department. From coordinative planning and cooperative effort it can be expected that not only will the health of the community be advanced, but that individual physicians will have a better understanding of their patient's needs.

"In view of the fund of information about the population, position of cooperation with official and quasi-official organizations, and facilities for statistical analysis which are possessed by the Hagerstown office of the United States Public Health Service, it seems appropriate that the Division of Public Health Methods of the United States Public Health Service direct its activities especially toward the promotion of integrated effort in health research.

"It is recommended by the Washington County Medical Society that some action be taken in order to assure continuation of the work of the Public Health Service in this county in view of the uncertainties of budgetary conditions year by year. It is further recommended that a committee composed of representatives of the medical society confer with the county health officer to consider ways and means to achieve extension and continuation of the work of the United States Public Health Service in this community."

Very truly yours,

ERNEST F. POOLE, M. D., *Secretary.*

Mr. Poole. Mr. Chairman, this problem has been one of great interest to the medical society in Washington County. We feel proud that from the earliest days some of our citizens who were conscious of public health began by organizing a lay Washington County Public Health Association. That began about 1915. The work has progressed, and in our small community we have progressed by the help of the United States Public Health Service and the tuberculosis associations and the civic organizations cooperating. Finally, we had the good fortune to have a full-time health officer installed in 1930.

In the beginning, about 1921, the School of Hygiene of Hopkins began their educational program on the pattern and spread of contagious diseases. Records were kept, particularly family records, and these records have been kept very thoroughly over these years. A great deal of data have been collected, particularly with respect to the spread, the control, and the development of methods of controlling contagious diseases.

As a result of that, I might say that we find that 20 years ago, at the head of the list in mortality were diphtheria, typhoid fever, and the pneumonias and today we find a complete reversal, and I think in some respects it is due to the fact that we have had these studies on patterns, spread, and method of control of diseases, which have been passed on to the doctors of the county medical society and we feel that a step further should be made in regard to going somewhat further into this vast field of connected illnesses, and the medical society in Washington County is of the definite feeling that this work has been of great benefit to them in that community, to the people of the community, and that we should go on in research in this field of connected illnesses, which is ever increasing.

Thank you.

Mr. Priest. Doctor, just a second. There may be some questions.

Mr. Sadowski. Yes, Mr. Chairman.

Mr. Priest. Mr. Sadowski.

Mr. Sadowski. Doctor, how many families have you surveyed during this period of 20 years?

Dr. Poole. Dr. Prather can probably answer that better than I can.

Dr. Prather. We have data on 16,000 families. I have here a list of the records that run into the thousands that we have, various types of records on families. We have what might be looked upon as being a full record, almost everything that you would want to know, on the family, on about 2,000 families.

Mr. Priest. Will the gentleman yield?

Mr. Sadowski. Yes.

Mr. Priest. Where are those families located?

Dr. Prather. In Washington County.

Mr. Priest. In Washington County?

Dr. Prather. Yes, sir.

Mr. Priest. The 16,000 are located in Washington County?

Dr. Prather. Yes, sir.

Mr. Sadowski. That is all, Mr. Chairman.

Mr. Priest. Are there any further questions?

We thank you very much for your testimony, Doctor.

Dr. Poole. Thank you.

Mr. Beall. Thank you, Mr. Chairman,. We have no further witnesses.

I would like to say, though, sir, that I understand the same resolution is going to be introduced in the Senate by Senator Tydings and I want to again repeat that it is not our intention to ask for any funds at this time. Surveys are to be made and we want to let the Public Health determine in the next year what they think should be done.

Mr. BENNETT. I would like to ask Mr. Beall a question.

Are you familiar with these other bills that have been introduced here on the separate institutes?

Mr. BEALL. No, sir. I am familiar with the very splendid work that has been done in Washington County and the suggestion was brought here that it be brought to the attention of your committee, as to what has been done there.

Mr. BENNETT. I appreciate the interest you have had in this subject and the time you have given to it; but it occurs to me that if we pass legislation establishing separate institutes, authority will be given to do what you want to do in your bill.

Mr. BEALL. I would rather have Dr. Perrott answer that question, because I am not familiar with it.

Dr. PERROTT. Do you want me to say something? I am not a legal expert but I understand this is not a bill in the real sense which requires that something be done. It is a joint resolution, I believe, which would express the approval, if it passes, of Congress of the expansion of these studies. It would not provide the funds. We do not need authority. I think the Public Health Service at the present has legal authority to expand it, but expansion requires funds. If this resolution were passed, it would indicate then that Congress thought this kind of work was important. We would then go through the usual processes, through the Budget Bureau and Appropriations Committee to get the money. This is not a bill, as I understand it, in the usual sense of the word.

Mr. PRIEST. It is a concurrent resolution.

Mr. BEALL. Thank you.

Mr. PRIEST. If there are no further questions, we thank you, Mr. Beall, and other witnesses on this subject.

STATEMENT OF HON. A. L. MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEBRASKA

Mr. PRIEST. The next bill before the committee this morning is H. R. 4874 introduced by our colleague from Nebraska, Dr. Miller.

Mr. MILLER. Thank you.

Mr. PRIEST. We are glad to have you, Doctor.

Mr. MILLER. If the Chair will permit me to address myself for 1 minute to the previous resolution, I would be happy to do so.

Mr. PRIEST. We shall be very happy to have whatever you want to give us on any of these subjects.

Mr. MILLER. Research, according to my way of thinking, is probing the unknown and trying to find out the cause of disease.

As a physician of 31 years' experience, several years as a State health director, I rather felt in looking the resolution over that the authority now rests in the Public Health Service to do all types of studies in research and special statistics, upon the causes of diseases. You do not eliminate chronic disease by a Ph. D. studying statistics.

It is done in the laboratory. It is done by experience over many years.

It has been the hope of humanity from the beginning, to find the fountain of youth, to eliminate disease, but chronic diseases are always with us and are a real problem, and anything this committee can do to help solve some of the chronic diseases, well and good, but I expect that they will be with us just as the tides are with us and just as the law of gravity continues to be in effect.

It is true the medical profession has, by research and probing into the unknown, extended the span of human life many years. I will always thoroughly endorse research, but my feeling is that present authority now exists.

Now, as to H. R. 4874, the bill presently before you, I introduced it on May 26. It calls for a commission to investigate the medical care problems of the United States, and of other countries.

I suggested seven members, two to be appointed by the Speaker of the House, two by the President of the Senate, and three appointed by the President.

It is a bipartisan commission, no four of them of any political party.

Mr. Bennett. Pardon me, but what is the number of the bill?

Mr. Miller. 4874.

The thought behind the introduction of the legislation was this, that this committee has before it the question of some form of insurance for medical care, and it is an important problem for the American people, and I believe that the Congress and the people of the United States ought to have all of the uncolored factual information they can obtain before we launch into any large-scale change in our present medical care system and public health problems.

The commission, if appointed, would have authority to study all forms of medical care, insurance, and problems now in existence in the United States and in other countries.

I think it is essential, if we are going to adopt some form of prepaid insurance for health, that we take a look at what England is doing. They will soon have a year's experience in England. New Zealand has been having it a number of years. Norway and other countries have, and we ought not to make any mistake in this country as to the direction we propose to go. If we are going to have some form of prepaid insurance, let us have all of the facts, and then the Congress and the people of the United States will be in a better position to act upon, intelligently, the problem before them, and if the committee feels that it is worthy, I would like to see it reported to the House.

If you feel that it ought to be a larger commission or a smaller commission, I have no pride of authorship in that particular approach.

It might be likened to a small Hoover Commission, to go into every detail of the present prepaid insurance, voluntary plans, compulsory plans, the plans of industrial organizations, and from that study they should report back to Congress within 18 months and then from that study I believe that this committee and the Congress would be in a better position to act intelligently.

I think that is the only statement I have to make, Mr. Chairman.

Mr. Priest. Doctor, we thank you very much for your statement and your interest in the question of health, and I think that all of the members of the committee who have followed your interest through the years know that you have always been intensely interested in all legislation that would improve the health of the people of the Nation.

Are there any questions?

Mr. SADOWSKI. Yes, Mr. Chairman.

Mr. PRIEST. Mr. Sadowski.

Mr. SADOWSKI. Well, would it be the purpose of your bill to forestall any action on the health insurance bill for 18 months, then? Is that what you intend?

Mr. MILLER. I would think that the committee would want all of the information they could get about the current health plans in England, New Zealand, Norway, and other countries before we try to adopt something for 150,000,000 people in the United States.

Mr. SADOWSKI. Well, would it be your further intention to forestall action on these other health bills that we have before us?

Mr. MILLER. Well, I do not know what other health bills, particularly, you refer to, sir. If you refer to community health, or socialized medicine, naturally, the committee would not take any action on that particular type.

Mr. SADOWSKI. Hospital construction, for instance; the nurses program.

Mr. MILLER. No; I am thoroughly in accord with the approach of the hospitalization, the Hill-Burton bill; aids to medical students and dental students who need some help; and enlargement of the public health facilities. I think that should proceed. I think it is needed.

I think it would proceed, anyway, and I think it should proceed. This goes to the heart of the medical-care proposition of the individual, whether it is going to be on a voluntary insurance plan or some type of compulsory insurance plan, and I was hoping that the committee and the Congress and the people of the country could get the facts. When they know the truth and the facts, I am not concerned or worried about what action they may take. They may want to adopt compulsory health insurance.

I am convinced in my own mind that some change is approaching the American people in their medical-care problems. Whether it is going to be a pay-roll-deduction bill that is going to take something out of the pay checks—maybe it is compulsory insurance or the voluntary plan.

When I first came to Congress I introduced legislation for the old-age-assistance group. I found in my own State we were paying out more money for care, for old-age assistance, for medical-care problems than would be necessary to buy an insurance policy for them that would permit those people when they were ill to get a doctor, or a nurse, or to go to a hospital, without all of the red tape that they had to go through under the old-age-assistance program.

I still think it ought to be done for those old people. Most illnesses are due to the feeling, "Well, if I am going to get sick, where will I get a doctor?"

At the present time, under the old-age-assistance program, it is just almost impossible to get approval in some counties for that individual who is ill to call in a physician of his own choice, and I think under that group alone you could set up the money that presently is being paid out for their care through the States and Federal Government and you could set up an insurance program with a private insurance company which would guarantee them hospital care, dental care, nursing and medical care, without going through all of the present red tape that they must go through in order to get their care. That was the feeling that I had in connection with that particular matter, but as to the other research programs, and the enlargement of the public health, the Hill-Burton bill, medical aid, aid for some worthy medical students and dental students, I think is meritorious and the committee should proceed with that.

Mr. WILSON. Mr. Chairman.

Mr. PRIEST. Mr. Wilson.

Mr. WILSON. I would like to ask you this, Doctor. I notice on page 4 of H. R. 4874, that a report is to be made by the proposed nonpartisan medical-care investigation commission within 18 months after its creation.

Mr. MILLER. Yes.

Mr. WILSON. What would be the status of it if they were unable to reach unanimous report or a report that could be submitted?

Mr. MILLER. Well, I would not think that the report necessarily needed to be unanimous, but we ought to have all of the facts. I am not particular whether it is within 18 months. If the committee thinks they can do it within 12 months, that is O. K. If it takes 2 years, or whatever the committee feels would be necessary, that is all right. I put in the figure 18 months, thinking of the Hoover Commission, which I believe was 18 months.

Mr. WILSON. You also have in here under section 7, that 90 days after the submission of the report, the commission ceases to exist?

Mr. MILLER. Yes, sir.

Mr. WILSON. By that, I presume, you want a safeguard against having another continuing so-called temporary commission?

Mr. MILLER. That is right. That is patterned exactly after the Hoover Commission. It is the same language which provides that the Hoover Commission work under when we set that commission into action. It works exactly the same. The Hoover Commission has now ceased to exist.

I would hate to see a commission set up which would go on indefinitely. I think it ought to be for a definite time for them to report. If the committee thinks 6 months is sufficient, which I think would be too short a time, or maybe a year would be sufficient, that would be well and good. But, I just feel that your committee and the Congress ought to have all of the facts about not only the different medical-care systems in this country, voluntary insurance; industrial health insurance—and every large industry has their prepaid type of insurance—medical-care programs for their workers; and then take a look at what England, New Zealand, and other countries are doing. After you have all of the facts, gentlemen, you will not have any trouble making your decision. I am quite sure of that.

Mr. WILSON. In response to one of the committee member's questions about what it covers, you said "medical care." I notice here that you endeavor to state, in section 8, on page 4 of your bill, what "medical care" is. It includes surgical care, hospital care, preventive medicine, and all other kinds of medical care and include insurance with respect to any such care.

Now, I was interested in what you had to say about hospital care. Would you propose to withhold the hospital program back, not go forward on the hospital construction program, as it might relate to hospital care?

Mr. MILLER. No. I answered that question here just a minute ago. I think that those programs ought to go forward; but if you are going to make a study of the medical-care propositions of the United States, it must include all preventive care, public health, hospitalization, surgical, and all of the present systems now in operation for the care of the American people.

Mr. WILSON. That was what I was getting at. It seems to me like your definition of medical care as it relates to hospital care would portend, at least, maybe envision holding any action of this committee or Congress at the present time as relates to hospitals and hospital-care patients, until a report was finally submitted by your proposed commission.

Mr. MILLER. No. This legislation says nothing about hospitals and on that type of legislation, I would not want to do anything that would retard that, because I approve of that type of legislation.

Mr. PRIEST. If that is all, we thank you.

Mr. SADOWSKI. Mr. Chairman.

Mr. PRIEST. Mr. Sadowski.

Mr. SADOWSKI. It seems to me, Congressman, that when these hearings are concluded and a report is written, and a report is made based upon the testimony of the witnesses that have appeared before this committee, that all of the study and information that you have referred to in your bill will have been pretty well covered. The report will be quite comprehensive. We have been at this thing now for many weeks, and we have had everybody here, the outstanding men in health, medicine, and science have been before this committee and have given us a terrific amount of information.

Mr. MILLER. More heat than light sometimes.

Mr. SADOWSKI. It seems to me that it is a matter now of studying that information that has been presented before us and coming to a decision. I do not know how much more can be accomplished by waiting another year and a half before taking action.

Mr. MILLER. Well, frankly, this strikes at the socialized-medicine problem. I am sure that the gentleman is not optimistic enough to think that that is going to get through at this session of Congress—before hot weather is over, at least—and even at the next session of Congress, and I was hoping that the committee would like to get a little information that would be helpful to them. If they do not want it, then forget about this.

Mr. SADOWSKI. I was going to say, that we have received so much information from both sides——

Mr. MILLER (interposing). And I was going to say that there had been more heat than light in most of that, and I would like to see you get a little light upon it before you decide.

Mr. SADOWSKI. Of course, we thought we had quite a lot of information when we received the Federal Security Agency's report that was filed at the request of the President of the United States. That is quite a thorough and comprehensive report.

Mr. MILLER. But it is not concurred in by the majority of the physicians who were on the panel.

Mr. SADOWSKI. But since then we have had the representatives of the AMA.

Mr. MILLER. Yes.

Mr. SADOWSKI. And those in opposition, and a vast amount of data and information has been furnished.

Mr. MILLER. Have you had information on how England is doing in their year's experience, in England?

Mr. SADOWSKI. Yes, we have had information on that also.

Mr. MILLER. A good look-see there might be quite informative.

Mr. SADOWSKI. I think the important thing now is to have the Members of Congress study this report that will come out of this committee in connection with these hearings. It will give them probably all of the information they need.

Mr. MILLER. I have no objection to studying that report but I submit that you ought to have a bipartisan report for a study such as the Hoover Commission report might have brought out to add to the information you already have.

Mr. PRIEST. Are there any further questions?

If there are no further questions, Doctor Miller, we thank you for your appearance before the committee.

Mr. MILLER. Thank you very much.

Mr. PRIEST. Without objection, there will be included in the record at this point a letter from the Federal Security Agency. Copies of that for the committee are in that composite list.

There is a brief statement from the Department of Labor, that will be included; a letter from the Civil Service Commission suggesting an amendment of the legislation which should be adopted, will also be included at this point; and a letter from the Veterans' Administration in which no recommendation is made is included without objection at this point in the record.

(The letters above referred to are as follows:)

FEDERAL SECURITY AGENCY,
Washington, June 16, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This is in reply to your letter of May 27, 1949, requesting a report on H. R. 4874, a bill "For the establishment of the Medical Care Investigation Commission."

H. R. 4874 would establish a commission of seven members to "study and investigate all phases of medical care in the United States" for the purpose of determining (1) in what respects existing medical care in the United States is inadequate, and (2) what are the best methods of remedying inadequacies. The commission would be required to report its findings and recommendations to Congress within 18 months from the time when the majority of the members took office. The commission would be composed of two members from the Senate appointed by the President of the Senate; two from the House of Representatives appointed by the Speaker, and three members appointed by the President from the executive branch or from private life. Not more than four members could be from the same political party. The commission would be authorized to appoint staff up to the number of five, to hold hearings and to require the presence of witnesses and the production of documentary evidence. All departments and agencies of the Government would be directed to furnish information, estimates, and statistical data upon request of the chairman.

While competent and impartial studies are always valuable, particularly for the evaluation of the effectiveness of operating programs, the present proposal for a new commission which would study and investigate all phases of medical care and all existing and proposed programs and plans as a preliminary to recommending "methods of remedying such inadequacies" seems unnecessarily duplicatory and delaying. There is now available sufficient information to establish the areas in which governmental action is necessary and would be appropriate and to determine the general outlines of the necessary program.

A number of governmental agencies and specially constituted bodies have been making extensive studies and investigations in this field for a considerable number of years. For example, the Committee on the Costs of Medical Care—under the chairmanship of Dr. Ray Lyman Wilbur, former president of the American Medical Association and Secretary of the Interior in the Hoover administration while serving on the committee—conducted a 5-year series of studies. The work of the committee and its collaborating agencies comprises some 30 published reports on the economic aspects of the occurrence, prevention, and care of illness.

Other comprehensive studies that may be cited are:

The National Health Survey, 1935–36.

Consumer Purchases Studies of Medical Care Expenditures, 1935–36, Department of Agriculture and Department of Labor.

The Interdepartmental Committee to Coordinate Health and Welfare Activities, 1938–39 (Bulletins of the Technical Committee on Medical Care).

The National Health Conference, 1938.

Federal Security Agency, Social Security Board: Prepayment Medical Care Organizations, 1945.

Federal Security Agency, Public Health Service: Blue Cross and Medical Service Plans, 1947.

American Medical Association, Council on Medical Service, "Voluntary Prepayment Medical Care Plans," 1948.

"A Survey of Accident and Health Coverage in the United States, November 1948."

National Health Assembly, 1948 (proceedings soon to be published).

There have also been innumerable independent studies by both public and private agencies such as the Brookings Institute (The Issue of Compulsory Health Insurance, 1948); the Commonwealth Fund (Medical Services by Government—Local, State and Federal, 1946, Health Insurance in the United States, 1946, and Hospital Care in the United States, 1947); the Coal Mines Administration (A Medical Survey of the Bituminous Coal Industry, 1947); and Northwestern University (Studies in the Social Sciences No. 5—Compulsory Health Insurance in the United States; an Analysis and Appraisal of the Present Movement, 1943).

In addition, extnsive hearings were held on these issues before the Senate Committee on Education and Labor in the Seventy-ninth and Eightieth Congresses and the Senate Committee on Labor and Public Welfare is currently conducting further hearings in connection with S. 1679, S. 1456, and S. 1581. The testimony on these and the preceding bills and that before the House Committee on Interstate and Foreign Commerce on H. R. 4312 and 4313, constitutes a voluminous record of fact and opinion on most of the questions relating to medical-care problems which are currently under debate.

There are considerable areas of agreement on the main fields in which action is needed. The chief remaining disagreement is on the question of desirability and effectiveness of a publicly administered health-insurance system based on an earmarked tax as against a program based on heavily subsidized voluntary prepayment plans. This difference of opinion results more from differing political and social philosophies than from a lack of available information on the problems involved in the alternative solutions. It can be resolved as well by a thoughtful reexamination of existing data and by public-policy decisions by the Congress, now or in the near future, as after the collection of more material which would be largely cumulative in effect and which would only invite postponement by at least another 18 months of a decision which can and should be made now.

For these reasons we would recommend against the enactment of H. R. 4874.

Time has not permitted us to obtain advice from the Bureau of the Budget as to the relationship of this bill to the program of the President.

Sincerely yours,

J. Donald Kingsley,
Acting Administrator.

DEPARTMENT OF LABOR,
OFFICE OF THE SECRETARY,
Washington, June 21, 1949.

Hon. ROBERT CROSSER,
*Chairman, Committee on Interstate and Foreign
Commerce, House of Representatives, Washington, D. C.*

DEAR CONGRESSMAN CROSSER: This is in response to your requests for comments upon H. R. 4840, a bill "to provide for a survey of sickness in the United States," and H. R. 4874, a bill "for the establishment of the Medical Care Investigation Commission."

I am in agreement with the objectives of H. R. 4840. A survey of sickness and disability would be of assistance to the programs of the Department of Labor in the measurement of disability from industrial injuries, the collection of information concerning medical care plans as they affect collective bargaining relations between employers and employees, and in other statistical or research programs. Such a survey would be especially useful in providing an evaluation of the effect of long illness on the economic status of a sick person and his family and information on the number of persons of working age so disabled as to be unable to perform gainful work. It would also be helpful to the States in planning disability insurance legislation and to the Federal Government in the development of a national health program such as is contained in H. R. 4312. In no case, however, should the enactment of H. R. 4840 be considered justification for any delay in the adoption of such a national health program.

I should be opposed to the enactment of H. R. 4874 as unnecessary legislation. The adequacy of medical care programs in the United States and in other countries has already received thorough investigation. The need for a national health insurance program is established.

Because of lack of time we have not ascertained from the Bureau of the Budget the relationship of these proposals to the program of the President.

Yours very truly,

MAURICE J. TOBIN, *Secretary of Labor.*

UNITED STATES CIVIL SERVICE COMMISSION,
Washington, D. C., June 21, 1949.

Hon. ROBERT CROSSER,
*Chairman, Committee on Interstate and
Foreign Commerce, House of Representatives.*

DEAR MR. CROSSER: On May 27, 1949, you requested that this Commission furnish your committee a report on H. R. 4874. Your request was acknowledged initially on June 3, 1949. After consideration of the matters concerned the following remarks are submitted in connection with this proposed legislation.

H. R. 4874 provides for the establishment of a bipartisan commission under the designation of "Medical Care Investigation Commission." In brief, it appears that the function of the proposed Commission would be to look into all phases of medical care in the United States and submit a report to the Congress containing recommendations for correction of any inadequacies brought to light by its investigation.

It is evident that this is not intended to be a permanent independent agency since various provisions of the bill prescribe the limitations of its existence, i. e., a report to be submitted to the Congress within 18 months from the time when the majority of the members of the Commission first take office and the further provision for its abolishment 90 days after submission of the report referred to.

We desire to comment specifically on section 5 of the bill, which, under the heading of "Staff of the Commission," reads as follows:

"The Commission shall have power to appoint and fix the compensation of such personnel as it deems advisable, without regard to the provisions of the civil-service laws or the Classification Act of 1923, as amended. At no time shall the staff of the Commission exceed five persons."

As your committee is no doubt already aware, there are now in effect approved procedures adequate for the making of appointments to clerical, fiscal, and administrative positions such as would occur in an establishment of the type contemplated in this legislation. This would be equally so in the cases of essentially short-term temporary appointments, those for a specified period of time, or those made without limitation of tenure of office except as controlled by the life of the employing agency. Furthermore with respect to the employment of any specialists or consultants that might be required, there are also ample provisions for any exclusions from the usual civil-service requirements that might be in order. The Civil Service Act now empowers the President of the United States to authorize by Executive order, special appointments without regard to the usual competitive procedures in cases where there is a need for the services of specialists and consultants in other than permanent capacities.

For the above reasons, it is recommended that section 5 be revised as follows:

"The Commission shall have power to appoint and fix the compensation of such personnel as it deems advisable *in accordance with the civil-service laws and regulations concerned*. At no time shall the staff of the Commission exceed five persons. [Recommended change indicated by italics.]

Due to the short time available and the information we have received relative to the urgent needs of your committee, we have not had opportunity to obtain advice from the Bureau of the Budget as to whether H. R. 4874 is in conformity with the program of the President.

By direction of the Commission:

Very sincerely,

HARRY B. MITCHELL, *President.*

VETERANS' ADMINISTRATION,
Washington, D. C., June 15, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of May 27, 1949, requesting a report by the Veterans' Administration on H. R. 4874, Eighty-first Congress, "a bill for the establishment of the Medical Care Investigation Commission."

The purpose of the bill is to provide for the establishment of a commission to investigate and make a report and recommendations to the Congress regarding such inadequacies in medical care as may exist in the United States and the best methods of remedying such inadequacies.

The commission provided for in the bill would be composed of seven members, two from the Senate, two from the House of Representatives, and three from private life or from the Executive branch of the Government. The aforementioned report which the commission would make would be due within 18 months from the time when a majority of the members of the commisison first take office. It is provided by the bill that the commission would cease to exist 90 days after the submission of its report to the Congress.

The scope of the investigation of the commission would be quite broad. It would include a study of all phases of medical care in the United States, including all existing and proposed governmental and nongovernmental programs and plans for medical care. "Medical care" is defined in the bill to include surgical care, hospital care, preventive medicine, and all other kinds of medical care, including insurance with respect to such care. Authority would be given the commission by the bill to secure information, suggestions, estimates, and statistics from any department or agency of the Government in carrying out its mission.

It does not appear from the terms of the bill that, apart from supplying such official data as may be required by the commission under the provisions of section 9 (b), any administrative responsibility is intended to be imposed upon the Veterans' Administration, upon request therefor, would undertake to furnish such relevant information concerning the hospital and medical care program provided for veterans under laws administered by the Veterans' Administration as may be appropriate. It is not possible at this time to estimate any cost which might be entailed thereby.

The establishment of a commission such as is proposed in the bill involves a matter of basic national policy for the Congress to determine.

Advice has been received from the Bureau of the Budget that there would be no objection by that office to the submission of this report to your committee.

Sincerely yours,

O. W. CLARK,
(For Carl R. Gray, Jr., Administrator.)

Mr. PRIEST. Our next bill for consideration is H. J. Res. 7, providing for research in Alaska. This is sponsored by our colleague, the Delegate from Alaska, Mr. Bartlett. He is present and we would like to have him come forward at this time. Before we hear Mr. Bartlett, however, without objection we will insert reports from the Federal Security Agency and the Federal Works Agency.

(The reports are as follows:)

FEDERAL SECURITY AGENCY,
Washington, D. C., June 16, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of January 12, 1949, for a report on H. J. Res. 7, a joint resolution authorizing an appropriation for construction of buildings and facilities in or near the University of Alaska for research in Arctic health.

The joint resolution would provide permanent research facilities in order to make possible the conducting of Arctic health studies by the Public Health Service in cooperation with the medical departments of the armed forces and with other public and private agencies. It would establish an institute of Arctic health studies on the grounds of the University of Alaska by authorizing the construction, furnishing, and equipping of suitable and adequate buildings and facilities.

The resolution recognizes that serious health and sanitation deficiencies in the Territory of Alaska have been major factors in retarding the economic and social development and the settlement of the Territory. The importance of Alaska, both for our national economy and for its strategic position for purposes of national defense, makes it imperative that the country exert every effort to eliminate any factors which might interfere with the development and utilization of the resources of the Territory. This means that serious and long-term study should be devoted to the improvement of Alaska's health problems; this is of paramount importance in the establishment of a stable population and a healthful and desirable environment.

Alaska today is, to a great extent, incapable of meeting normal demands for decent housing, safe water and food supplies, and minimum protection against disease. The many and serious health problems which exist in Alaska are not conducive to permanent settlement. For instance, tuberculosis is a leading cause of death in Alaska, the mortality rate from this disease among natives being 16 times the average rate for the continental United States. The tremendous influx of people following World War II has created serious community sanitation and communicable disease-control problems, which are further complicated by difficulties of water supply and sewage disposal in Arctic areas. The prevalence of intestinal diseases increases in areas having poor sanitation. Factors relating to physiological response to cold and to the acclimatization of the individual in the Arctic are numerous and challenging. These are only a few examples of the many health problems in the Arctic.

A most serious obstacle to be overcome in correcting health and sanitation deficiencies in Arctic areas is the lack of specific knowledge concerning the operation of physical laws, biological processes, and human adjustments under conditions peculiar to Arctic regions. Numerous instances could be cited of the need for extensive and continuing research in specific disease and health problems. There are indications, for example, that the tubercle bacillus in Alaska is different in some respects from the tubercle bacillus in the United States and that different factors influence the transmission of tuberculosis. The virtual disappearance, in the United States, of some forms of tuberculosis which are still very prevalent in Alaska indicates that there is a gap in our knowledge of the factors transmitting the disease. We possess no accurate knowledge of the incidence of animal diseases affecting man in northern latitudes and the factors influencing the transmission of these diseases. The entire science of epidemiology has been virtually unexplored in Arctic regions, although it is known that the epidemiological patterns of certain diseases vary markedly from those of the same diseases in temperate climates. Insect control presents special problems in Alaska because of the almost limitless expanse of surface water in summer, which breeds countless numbers of mosquitoes and other insects, and because of drainage problems resulting from frozen ground. Our entire concept of water supply and sewage must be revised when Arctic areas are involved, since permafrost conditions preclude normal water supplies and water-carried sewage systems. These examples indicate only a few of the health fields in which special investigation under Arctic conditions is required.

A solution for these many problems can only come through long-term research in conditions peculiar to these regions. Previous research activities in the Arctic regions have been limited, for the most part, to expeditions involving short-term research. For those reasons, a permanent Arctic research institution, such as is proposed in this resolution, is necessary. Such an institution should contain necessary laboratory facilities and equipment for research in Arctic health and should serve as a base for continuing field investigations. The development of such an institution does not mean, of course, that existing specialized facilities at the National Institutes of Health and elsewhere would be ignored or not utilized. It would be impossible, however, to conduct the necessary studies without the facilities which would be available in the proposed institute in Alaska. Effective field investigations depend upon the proximity of laboratory facilities and technical consultative services to the actual conditions which are to be studied.

The need for a research center in Arctic regions has been recognized by leading organizations interested in Arctic areas. The National Military Establishment has endorsed the establishment of such an institution. A group of medical specialists sent to Alaska by the American Medical Association has confirmed the need for an Arctic research center. In a special report on Medical Conditions in Alaska, published in the Journal of the American Medical Association, October 25, 1947, this group made the following recommendation:

"Arctic Institute: An Arctic institute for the study of the Arctic and its bearing on health, sanitation, nutrition, engineering construction, food, clothing and footwear is recommended. This should be set up at the University of Alaska with Federal funds, and it should coordinate the efforts of the armed forces and the various Federal agencies. The resultant effects on the civilian economy of efficient means of heating, construction, sewage and water supply would be a boon to Alaskan development and defense."

A recommendation for the development of such a center was also made by the Secretary of Interior after a trip to the Territory in 1946.

In our consideration of the joint resolution, we have consulted with official and private groups interested in Arctic research with the view toward determining their current and planned activities. As a result of these consultations, we are confident not only that there will be no overlapping or duplication of research and investigative activities, but that the proposed institute will augment and aid the research activities of these groups.

For the reasons set forth, we strongly recommend that House Joint Resolution 7 be enacted by the Congress. It is our understanding that section 321 (a) of the Public Health Service Act, which vests the Surgeon General with the authority to select sites for and to establish research institutes in the various States (including Alaska), already affords authorization for the appropriation of funds to construct and equip the proposed institute. However, enactment of the resolution would serve to indicate the clear intent of the Congress with respect to this vitally important project. It would also serve to remove any possibility of doubt as to the legality of locating the institute on the grounds of the University of Alaska.

Time has not permitted us to obtain advice from the Bureau of the Budget as to the relationship of this bill to the program of the President.

Sincerely yours,

J. DONALD KINGSLEY, *Acting Administrator.*

FEDERAL WORKS AGENCY,
Washington, June 27, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

MY DEAR MR. CROSSER: This is with reference to your letter of January 12, 1949, enclosing a copy of House Joint Resolution 7, entitled "Authorizing an appropriation for construction of buildings and facilities in or near the University of Alaska for research in Arctic health" and requesting a report thereon.

The proposed legislation would authorize the Administrator of the Federal Works Agency to acquire a site and construct buildings and facilities thereon, in or near the University of Alaska, for the accommodation of the Public Health Service.

Although we have not been informed as to the program of the Public Health Service in Alaska and are, therefore, not in a position to express an opinion as to the amount of money necessary for building projects in the Territory, this Agency will undertake the proposed construction if the Congress deems it advisable.

The Bureau of the Budget has advised us there is no objection to the submission of this report to your committee.

Sincerely yours,

PHILIP B. FLEMING,
Major General, United States Army, Administrator.

STATEMENT OF HON. E. L. BARTLETT, DELEGATE TO THE CONGRESS FROM THE TERRITORY OF ALASKA

Mr. BARTLETT. Thank you, Mr. Chairman and members of the committee.

My name is E. L. Bartlett, Delegate from Alaska.

House Joint Resolution 7 would authorize the establishment at the University of Alaska of an Institute of Arctic Health. The Alaska Department of Health has prepared a pamphlet on this proposed Institute which I will give to the committee members.

(The pamphlet has been placed in the committee files.)

Mr. BARTLETT. The bill has been favorably reported by the Federal Security Agency, and Dr. J. W. Mountin, Assistant Surgeon General, is here, and later will be prepared to answer questions. He will have no formal statement, since the views of the Agency are incorporated in the report.

Also here to make a short statement is Dr. Laurence Irving, who recently has returned to the States, after spending most of the last 2 years at Barrow, Alaska, with the Office of Naval Research. He can give you an intimate picture of the conditions there and in the Arctic generally.

Now, this Joint Resolution No. 7 would authorize the appropriation of $7,775,000 for the establishment of the Institute of Arctic Health, as I say, at the University of Alaska, which is located about 4 miles from Fairbanks, Alaska, less than 200 miles south of the Arctic Circle. The university is considered an ideal location for such an institute.

In general, I think it ought to be said here that the United States has been woefully delinquent in the matter of exploring Arctic and subarctic possibilities. Alone of all of the great nations in the world having northern possessions, it has done practically nothing. I could illustrate that with this chart and you can see it; this is a chart of world. Over here in Soviet Siberia there are, I believe, now, about 40,000,000 people. A great economy is going up in that part of the world. Russia has established there great industries, such as steel. It has done long-time research in agriculture, the result being that a very considerable agricultural economy exists there. They have cities of a quarter of a million people and more, and many of them. We don't know, of course, everything that is going on there now, but the meager information which reaches us is that the tempo of progress across the Behring Strait from American territory has not slowed. On the contrary, it has been accelerated.

The problem of expending this sum or any sum of money on such a subject, of course, is one that is properly of concern to the Congress. I think that there are two things that I could say in response to that point: One is that if we do not get a central institute of this kind right on the ground, we will probably spend that much money or more, anyway, because Government agencies will go out independently and try to discover the answers to some of the health problems that confront them in the Arctic; what shall they do about sanitation; how about mosquito control; and so forth, and so on, over a long list of subjects.

There are two objections to that procedure: One is that it costs a lot of money, and the other is that without central organization and central control the results naturally are not as good as they otherwise would be. So I think that from the standpoint of economy a demonstration can be made that a central institute such as this proposed here would be effective; and there is another point, and one which I should think is much more important: Without quarreling at all with the proposition that we send hundreds of millions of dollars and billions of dollars, perhaps, ultimately to countries such as Greece and Turkey, I always have had a strong feeling that if war actually did come, no matter what we poured into nations such as those, they inevitably would be overrun.

But suppose we dilly-dally in Alaska as we have been doing ever since the war ended. Then very easily it could be a proposition not simply of Alaska, American territory such as it is, being overrun, but of this Nation being badly crippled. We have in Alaska some splendid air fields—Army air fields. We do not defend those air fields adequately at all. We have—and this is no secret at all; it is known to everyone; it has been in the public print throughout the months and years—very few combat soldiers in Alaska. It is generally recognized that these great air bases at Anchorage and around Fairbanks could be taken without any great difficulty.

If they were taken by an enemy, he would discover himself only 1,525 air-miles from Seattle, only 2,790 air-miles from Chicago, only 3,270 air-miles from Washington, and only 3,255 air-miles from New York.

With the development of the modern bombing plane, it is obvious what possession of those air fields in Alaska could mean to an enemy power.

During the last war, Alaska was the only American soil that was occupied by an enemy, as we all recall the Japanese took some of the outer Aleutian Islands.

I have heard that the money cost of the expedition that we sent up to Kiska to reclaim that territory for ourselves, not taking into account the loss of life and suffering, was $3,000,000,000. If war should come again, it might not be a proposition of money cost. It might be a nation lost. And I think that we can tie in a very exact way this proposed Institute of Arctic Health into the whole program up there.

A year ago the President sent a special message to the Congress on Alaska, in which he outlined a comprehensive program for the development of that area, and in recognition of the fact that the Army, the military forces, cannot live in a vacuum. They need a strong, large civilian community back of them for production purposes.

That program has gone forward very slowly. We find that in a Territory such as that, even under the stress of a great national need, such as we are confronted by now, that our appropriations are generally the first to suffer. It is easier to cut from a Territory. In normal times that is bad enough. In times such as these, it might be ruinous to the Nation.

The Government during recent years has moved forward agressively, I am happy to say, in the field of controlling tuberculosis in Alaska, which is on the order of 16 times worse than anywhere in the States on the national average. When I came down to Washington in 1945, there were less than 100 hospital beds in all of Alaska for the care of the tubercular. Now we have many additional beds, and others are in process of being constructed. But that is the only health problem we have really tackled.

With the existence of an institute such as is proposed here, basic research that has never been done before by the United States in problems relating to the northern latitudes can be accomplished. I would like to suggest that affirmative action cannot be taken too soon. In the report from the Federal Security Agency to which I have referred, you will find that the Secretary of the Interior, after having made a trip to Alaska in 1946, joined with others in proposing that this institute be constructed. The American Medical Association sent a team to Alaska to look into health matters. The report of that group likewise suggests that very beneficial results would flow from the existence of such an institute.

I think, Mr. Chairman, that is all I have to say. I do want to emphasize the importance of this proposed institute in connection with a well-rounded development program for Alaska, and I want to say again that that program cannot come into being too soon, not only for the sake of Alaska, but for the sake of the whole country.

Mr. Priest. Thank you, Mr. Bartlett. You have made what to the Chair appears to be a very logical argument in favor of this resolution.

Are there any questions?

Mr. Sadowski. Outside of the tuberculosis facilities that have been provided for the treatment of tuberculosis, what is the extent of the other hospital facilities now available in Alaska?

Mr. Bartlett. Oh, we have a mixed situation. In some of the communities we have very good although quite small hospitals. Many of the hospitals in Alaska are operated by Sisters of the Catholic Church, and they have done excellent work there. The hospitals at Ketchikan, for example, Juneau, Anchorage, and Fairbanks.

Mr. Sadowski. How many small hospitals have you all told?

Mr. Bartlett. Offhand I would say about ten. The Methodist Church operates hospitals at Seward and at Nome, and other places do not have hospitals at all that need them; so that is why I say the situation is mixed in each of the larger communities that I have named. There is a very urgent need for expansion, and the groups concerned are trying to secure money now through their usual means to put on the additions. The Army, of course, has its own hospitals.

Mr. Sadowski. Are they overcrowded?

Mr. BARTLETT. Yes. That is particularly so at Anchorage and Fairbanks, where the population increases have been heaviest. Yes, quite crowded there now.

Mr. BENNETT. Mr. Bartlett, I think you have a good bill, and I can very easily give it my support. I am wondering about your statement on the defense of Alaska. If your conclusions are true that it is inadequately defended, I am wondering how well advised it would be to spend all of this money up there for purposes of this type.

Mr. BARTLETT. Let me say this in the first place: It is part of the United States, and I don't suppose that under any circumstances we would willingly relinquish American soil to anyone else; and if this institute were constructed—we will say it was completed by this fall, which it won't be—and the enemy attacked it, it would be taken with other things. However, now, there is before Congress a bill which will allow acceleration of the building of Army housing. That has been the great lack up there. That is why we do not have the combat troops in sufficient numbers to protect those great air bases. because the war was over and tension existed, but we let the building job go from year to year, and it needs to be done now and done promptly.

Of course, you cannot foretell the future. If the worst befalls, it befalls. But if we joined together in this program for the defense of Alaska, and for the development in the civilian sense of Alaska, without undue delay, we can hope that the job will be completed in time, and that Alaska then would present such a formidable obstacle to any invader that he would not want to tackle it.

Mr. BENNETT. How much money, if you know, does the armed forces—Army Department, Navy Department—spend on research in Alaska now?

Mr. BARTLETT. There is no way to get an answer to that question.

Mr. BENNETT. I mean on medical research.

Mr. BARTLETT. Oh, medical research; I can't give you the answer to the question. To tell you the truth, I have attempted to discover once or twice, but you know how it is when there is a general appropriation and people are sent up on special missions, and so with that sort of thing you can never get a very good guess even.

Mr. BENNETT. Does the Army Department and the Navy Department have any research institutes up there that you know of?

Mr. BARTLETT. No; not as such. No.

Mr. BENNETT. How much money is the Public Health spending up there?

Mr. BARTLETT. How much is Public Health spending up there?

Mr. BENNETT. Yes.

Mr. BARTLETT. Public Health was given an appropriation by the Eightieth Congress especially for Alaska of either $1,000,000 or $1,200,000, to get going on this job. I am delighted to say it was put in in the House Appropriations Committee at the last minute on the presentation of testimony from our commissioner of health and others, citing the urgency of the problem. The Appropriations Committee this time continued that program with an appropriation of $1,300,000. They are just getting set up properly, of course, the program being very new, and no conclusive reports have been published.

Mr. BENNETT. Are they spending $1,000,000 a year up there now on public health?

Mr. Bartlett. They will have spent it at the end of the fiscal year, assuming they spend the whole appropriation, $1,000,000 or $1,200,000 for the fiscal year 1949.

Mr. Bennett. Do they have any facilities? Do they have research centers, or other things that are set up?

Mr. Bartlett. No; not yet.

Mr. Bennett. Are any funds provided for that?

Mr. Bartlett. For pure research as such; no. No building funds or no pure research projects.

Mr. Bennett. Does the Public Health have any buildings up there?

Mr. Bartlett. No; none at all, not one.

Mr. Bennett. Is there any provision in the appropriation for buildings?

Mr. Bartlett. No provisions. Dr. Mountin will correct me if I am in error, but I am sure there is no provision in the Alaska appropriation for buildings.

Dr. Mountin. None.

Mr. Bennett. I am trying to get an idea how much money is being spent there as compared with, say, one of the States of the Union. The Public Health up there—does it compare favorably to what they are doing, say, in the State of Illinois.

Mr. Bartlett. I am going to give a short answer and then call on Dr. Mountin, who would have more factual information.

Until this appropriation last year, the Public Health to all intents and purposes did nothing at all in Alaska. We have a Territorial department of health which struggles along under a very meager appropriation which I am happy to say is constantly being increased by the local legislature, so that the program can be worked out in conjunction with the Public Health Service. Maybe Dr. Mountin would be in better position to tell you how it compares.

Mr. Bennett. Thank you.

Mr. Priest. Any further questions?

Mr. Stanley. Mr. Bennett asked the questions I had in mind. Thank you.

Mr. Gillette. No questions.

Mr. Wilson. No questions.

Mr. Priest. We thank you very much for your clear statement of this problem, and the needs.

Mr. Bartlett. Thank you.

Mr. Priest. Dr. J. W. Mountin, Assistant Surgeon General, is present and is familiar with this subject. We will be very happy to have you come forward.

STATEMENT OF DR. J. W. MOUNTIN, ASSISTANT SURGEON GENERAL, UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY

Dr. Mountin. I have no prepared statement, Mr. Chairman. The agency submitted a statement under the June 16 date which I trust is in your possession.

Mr. Priest. Yes; it is.

Dr. Mountin. My purpose in coming here is to answer questions that you wish to ask, or, if you choose, to elaborate on the statement that has been submitted to you, if I may.

Mr. PRIEST. I note from the statement sent up by Mr. Kingsley, Acting Administrator, that the Federal Security Agency favors this legislation, recommends that it be passed.

Dr. MOUNTIN. That is correct, sir.

Mr. PRIEST. The appropriation called for in the resolution is $7,775,000. That appropriation would be used for acquiring land, erection of building, and equipment, and other facilities.

My question then is, Supposing that this appropriation be made available for providing the physical facilities, do you have any estimate on what the annual appropriation might be for maintaining and continuing the research?

Dr. MOUNTIN. We have estimated it will be $1,300,000. That is an estimate.

Mr. PRIEST. It is true, is it not, Doctor, that the question of Arctic health presents quite a different question to the public-health problems generally, because it is of a very different nature in many respects? Is that not true?

Dr. MOUNTIN. That is correct, according to the best of our information. I must admit, however, that our information on the disease problems of Alaska, as well as the factors which underly those diseases, is very inadequate; and it was to piece out that sort of information that it was felt that a facility of this type, built right on the ground, operating under conditions which obtain, was essential to unraveling many of the factors which are now prejudicial to life in colder climates.

Mr. PRIEST. The inadequacy of that information is due largely to the fact that there has not been such an institute or such studies made on the scene in the past.

Dr. MOUNTIN. That is correct. There has been, so far as was available in lierature that is now at our hand, very little research done, and I think that statement is correct. Professor Irving here, who will follow me, can elaborate on that, but there is a great deficiency on life in the Arctic, on such matters even as water supply, sewage disposal. We are dealing with an entirely different situation. Our methods of sewage disposal are based upon biological processes that operate under temperate and tropical conditions, whereas up there we are dealing with very low temperature where many of these processes exist. The water has to be obtained, and the ground is frozen the year around. It thaws out only to a verying distance from a few feet down to much greater depths. That is what we call the permafrost area, which occupies half or more—I think three-fourths of the Territory of Alaska.

Housing conditions present another problem. There are many insects, some of which may or may not be disease-bearing; but in any event they add to discomfort and make life rather miserable and, in some seasons of the year, in some localities, actually unbearable.

Mr. PRIEST. Are those insects characteristic or common only to that temperature area?

Dr. MOUNTIN. They have breeding conditions that are peculiar to that area, and those are not well understood. That is simply because they have not been studied.

Mr. PRIEST. Are there any other questions?

Mr. SADOWSKI. I was kind of surprised to read here in your report that Alaska is infested with mosquitoes. I thought maybe it was too cold for mosquitoes.

Dr. MOUNTIN. That is the surprise to many people who are not familiar with Alaska, but the mosquito density goes very high. The season is short, but they are very annoying. They come out in great numbers, far beyond anything we experience in this country.

Mr. SADOWSKI. They are not malaria-carrying mosquitos, though.

Dr. MOUNTIN. No. Whether they may carry other diseases has not yet been determined.

Mr. BENNETT. What about the general health of the people in Alaska, as compared to, say, the people in the States, here.

Dr. MOUNTIN. Among the native population, and I should say the population generally, so far as our information goes at the present moment, we would class it very much below, practically all of the diseases have higher incidences—that is, for different age groups—and such a general factor as nutrition is much lower than it is here in the United States.

Mr. BENNETT. Do they have any special types of diseases that have a high death rate that we do not have?

Dr. MOUNTIN. Tuberculosis is probably one of their greatest menaces. While much of that it due to the fact that we may be dealing with a different type of tubercule baccillus, different type of organism, or whether it is because of nutritional or housing conditions, there, has not not been fully evaluated, but the fact remains that the incidence is several times higher than here in the United States.

Mr. BENNETT. For tuberculosis?

Dr. MOUNTIN. That is correct, and a high proportion of bone and joint tuberculosis which is practically unknown in the States.

Mr. BENNETT. Do you feel from the studies you have made that is due to the climate?

Dr. MOUNTIN. We do not know.

Mr. BENNETT. What kind of research is being carried on up there by the War Department?

Dr. MOUNTIN. I am not too familiar with it. From what little I do know, it is research that has to do with, I am speaking now in the health field, that has to do with military operations, and I think many of them could not be directly translated into civil life.

Mr. BENNETT. How much money are you spending up there now?

Dr. MOUNTIN. At the present time we are spending $115,000 on what we could class as research. We have some small projects going with a very limited staff. We are dispersed in different parts of Alaska, where we can get some sort of housing accommodations for them. The military have given us some space. The Territorial health department has given us some space and then we are renting some quarters. The arrangements are very unsatisfactory.

Mr. BENNETT. One of your main problems, I take it, is the fact that you do not have adequate building facilities.

Dr. MOUNTIN. That is true, adequate building facilities and housing for those people, too, that we would wish to employ. That is as much of a problem as the actual laboratory space.

Mr. PRIEST. Mr. Stanley?

Mr. STANLEY. No questions.

Mr. PRIEST. Mr. Wilson?

Mr. WILSON. I noticed in one of the pamphlets that was passed around here awhile ago, Doctor, Arctic Health Institute, under the date of 1949, it refers to the fact that of the four countries which possess vast holdings within the Arctic, none save Russia has established research centers in such area.

Is it a fact that Russia does have research centers in the permafrost area?

Dr. Mountin. That is what we are told. I cannot answer authoritatively.

Mr. Wilson. You do not know of the activities in that respect on the part of our neighbor?

Dr. Mountin. I do not have access to their literature.

Mr. Wilson. Then is there any kind of health institute working in Alaska?

Dr. Mountin. There is the general health program of the health department, and there is the usual hospital and medical facilities, not as adequate as we have in the United States, but what is contemplated here is an institute for research, rather than for providing general or public health services, general medical or public health services.

Mr. Wilson. I noticed also in this same pamphlet emphasis upon the possibility of research on venereal-disease studies. Is that disease prevalent, or at a higher rate, in the Arctic regions than it is in the Temperate Zones?

Dr. Mountin. I cannot answer that question. There are different reports, but we have collected no data which would either show it was in excess or below. There are reports that it is high, although it has not been substantiated.

Mr. Wilson. I believe the Delegate, Mr. Bartlett, might have an answer for that.

Mr. Bartlett. On second thought, my answer probably would not be anywhere near as factual as Dr. Mountin's. The venereal-disease problem was accentuated when the Army went to Alaska about 1940, and it is a real problem there. So it has been of much concern to the Territorial department of health.

Mr. Wilson. Is the Territorial department of health carrying on studies as well as control?

Dr. Mountin. Their program is essentially what we would call service or control, rather than research. I think it is a fair statement to say they are carrying on no work which could be classed as research. Their service program, however, as far as it goes, is of high quality.

Mr. Wilson. I notice again in the bill itself presented by Mr. Bartlett, it speaks of the words "in cooperation with the medical departments of the armed forces" and "other public and private agencies." Are they carrying on any—not only control in the venereal-disease program, with what forces they do have in the armed services—but are they carrying on any research work?

Dr. Mountin. Not that I am aware of in the field of venereal diseases. I think their research, so far as I know, would be what would be regarded as research tied in closely with military operations.

Mr. Wilson. Thank you.

Mr. Sadowski. In that same report it states that Russia has succeeded in establishing a city of a quarter of a million population within the permafrost area. Well, if they have done that, then they must have solved the problem of sewage and water supply in order to take care of such a large population, it would seem to me. Have you any information as to what they have done in that particular city?

Dr. MOUNTIN. I have read this pamphlet rather recently for the first time. I am not familiar with the background information. But if that statement is correct, and I presume it is, they must have done something to solve the problem of water supply and sewage disposal. I think that is a fair assumption.

Mr. SADOWSKI. We have no information about it?

Dr. MOUNTIN. We have none.

Mr. PRIEST. Thank you very much for your statement, Doctor.

Dr. MOUNTIN. Thank you.

Mr. PRIEST. Our next witness will be Dr. Laurence Irving, of Swarthmore College, Swarthmore, Pa.

STATEMENT OF DR. LAURENCE IRVING, SWARTHMORE COLLEGE, SWARTHMORE, PA.

Dr. IRVING. If I may introduce myself, I will say that for some years I have been concerned in basic research in the biological and medical sciences, and during wartime have been concerned with the development and testing of equipment and procedures for the survival and the facilitation of human operations under difficult climatic and other conditions of exposure.

I have from time to time been concerned with the National Research Council in research and development in connection with problems of that sort. Recently, I have been in Alaska as an investigator of the problems of the survival of animals and man under difficult environmental conditions, and as that research developed, the Office of Naval Research deemed it desirable to establish an outlying laboratory or field laboratory from which field studies might proceed at Point Barrow, Alaska, the most northern project of Alaska into the Arctic Sea.

In connection with that work it has been my privilege, as well as my duty, to be frequently associated with the field investigators of the Public Health Service, and to discuss with their superiors and with their organization, as well as with the Territorial health department, the problems of basic and practical research in Alaska, and the methods which can be used in their solution.

I do not know whether you would now prefer that I should make a statement in order to raise questions, or whether you would wish to have me answer questions.

Mr. PRIEST. Are there any questions immediately on behalf of the committee?

Perhaps if you proceeded and made a statement, Doctor, it will be necessary for the committee to adjourn at 12 o'clock, since the House will be in session at that time, but if you proceeded to make a statement, it may suggest questions, if you care to do that, sir.

Dr. IRVING. Thank you, sir.

The problem of how man and animals can survive in extremes of climate can be best viewed by going to the extremes and not going to any halfway situation, and so the investigation of the existence and survival in cold can best be settled at the most Arctic point in American, which is in our own Alaskan Arctic area. That, strangely enough, gives bylights upon the survival of animals under tropical conditions, because there in the north we see one extreme, by contrast in the Tropics we see another extreme, and by interpolation, we can often get a better view upon conditions of survival in in intermediary area, such as the temperate portions of the United States. That is the sort of background behind basic research in the Alaska region.

With regard to the more applied research toward the health of the population, in the Arctic, along the Arctic coast, there are populations, native populations, which by isolation and by racial distinction are different from the people of the United States and their type of civilization. The coming of our civilization from here to them has not been an unmixed blessing for it has brought to those people diseases, new social and economic habits, and customs which have had a very powerful impact upon those people.

With their resistance to disease, the diseases to which we apparently are by long experience relatively well accustomed, proves to be rather low, so that they are scourged with the respiratory diseases, tuberculosis, influenza, things which we have constantly with us here, but which by custom, by knowledge and by treatment we have subordinated so that we do not think them to be major menaces to health. So likewise were some of the epidemic diseases which afflict children or certain groups of our populations here. Measles, for example, may sweep through adult and immature populations there with great damage. So we see those people are by whatever is their background susceptible to disease. We of course have interest in studying those conditions toward amelioration of their lot.

We have also as Dr. Mountin, and previous testimony, has indicated, the view that many conditions of health to which we are now well accustomed have just by that habituation on our part sometimes lost their point, their emphasis, and the study is thereby made more difficult, whereas by observing them among the people who react more violently, there is every likelihood, perhaps every certainty that that observation will reveal in the more potent manifestations of disease their conditions or other manifestations which will give clues as to the diseases here which we constantly suffer from, but which we are so habituated to, we really cannot see the main point.

Among these populations there appear to be, and this is still only a matter of observation, there appear to be perhaps a lesser affliction by those diseases which we now unfortunately regard as characteristic of the middle age and later middle age, such things as diabetes and some of the vascular and arthritic types of diseases. They appear to be rather less common among some of the native populations. And if that be true, as the evidence at present suggests, then we may have there an indication, and an experimental situation in which types of population exist more or less exempt from diseases to which our attention here is now being constantly developed in greater importance as most important scourges of our adult and later-age groups.

There is another point, too, which I think will impress many of us, that in the extreme conditions which are presented at those frontiers where life becomes difficult because of cold and other conditions existing in northern Alaska, there are not only important practical problems of health, but there are new outlooks and certain new perspectives to be gained in our view upon the existence of man and of life in general. Those problems present to the basic and to the practical scientist new challenges, which will assist in the solution of important problems here, which I think will as they have very markedly in the limited operations in the past, inspire to development of science, and, I believe, facilitate its application to human welfare in general.

In all of the operations of the various people concerned with research in Alaska, there has been constantly the feeling that it would be desirable to have a center, a physical center, as well as an intellectual center, through which the people working there might focus their activities, where they might meet and from which they might diverge in their various field activities, and this proposal seems to afford that opportunity in a very striking fashion, and one which I believe would be of the greatest usefulness.

Mr. PRIEST. Doctor, we certainly thank you for your statement. We are aware of the vast amount of information that you have on this subject, as compared to most of us, certainly, and your statement on the subject holds great weight with the committee.

Are there any questions now of Dr. Irving?

Mr. WILSON. I would just like to ask this one question of the doctor, Mr. Chairman.

You spoke of working in conjunction with field representatives of the Public Health Service in the survey study that you made up in that region. Do we have many such investigators of the Public Health, and briefly what is the extent of their activity?

Dr. IRVING. There have been in association with us at Point Barrow engaged in active field research thus far one investigator, a very able one, but still numerically only one.

As for this area of Alaska as a whole, that I cannot say. There is considerable work, but not—Dr. Mountin is qualified to answer on the whole extent of that activity. I feel that it is significant, but that the numerical numbers are very small compared to both the needs and the opportunities.

Mr. WILSON. That is all.

Mr. PRIEST. Doctor, we thank you very much for your statement and your interest in this subject.

Dr. IRVING. Thank you.

Mr. BARTLETT. With your permission, I should like to submit for the record a memorial of the Alaska Territorial Legislature bearing on this subject.

Mr. PRIEST. Without objection it will be included in the record at this point.

(The memorial is as follows:)

[In the House. By Mr. Franklin. House Memorial No. 19. In the Legislature of the Territory of Alaska, nineteenth session]

To the Honorable Harry S. Truman, President of the United States; the Congress of the United States; the Secretary of the Interior; and the Delegate from Alaska:

Whereas the difficulties and delays experienced by all nations in their attempts to establish a stable population and a sound economy in Arctic areas can be traced almost entirely to the faulty conditions of health and sanitation which are typical of these areas; and

Whereas inability to overcome these inadequacies of health and sanitation, is in turn, caused by a lack of specific knowledge concerning men's adjustment to the conditions which exist in Arctic and Sub-Arctic areas and little scientific information is available regarding the operation of physical laws and ordinary biological processes under conditions peculiar to Arctic regions; and

Whereas such information can be gained only through painstaking research and experimentation on a long-term basis and to be of value, such research must be of a scientific caliber, conducted on the spot under existing conditions, by trained specialists from many fields, with the necessary facilities and equipment to do a thorough job; and

Whereas research in Arctic health has been long delayed by lack of any suitable facilities which would enable qualified scientists to carry on a program of investigation of sufficient length and scientific thoroughness to produce conclusive results; and

Whereas in all of the Arctic area which lies within the Western Hemisphere, there is no facility or institution capable of meeting the basic needs of such an intensive program and of the four countries which possess vast holdings in the Aractic, none save Russia has developed research centers in this area; and

Whereas the obvious need for development of well-equipped Arctic health research institutes in the Western Hemisphere has long been recognized, and has frequently been expressed by leading authorities in Government, medicine, biology, and other fields; and

Whereas in recognition of the long-standing need for the development of research facilities in an Arctic area, the Alaskan Delegate in Congress has introduced into the Eighty-first Congress a resolution requesting congressional authority and appropriations for the purpose of establishing such a facility (H. J. Res. 7) at the University of Alaska; and

Whereas the board of regents of the university adopted a resolution donating land, ideally located adjacent to the university campus, as a site for the research center;

Now, therefore, your memorialist, the House of Representatives of the Legislature of Alaska, in nineteenth regular session assembled, respectfully urges enactment of such necessary legislation to bring about the establishment of an Arctic Health Institute in Alaska at an early date.

And your memorialist will ever pray.

Passed by the House March 18, 1949.

STANLEY MCCUTCHEON,
Speaker of the House.

Attest:

JOHN L. HEDDE, *Chief Clerk of the House.*

Approved by the Governor March 21, 1949.

ERNEST GRUENING, *Governor of Alaska.*

A true copy, I certify.

CELIA THEILE, *Clerk, Secretary's Office.*

Mr. PRIEST. The committee has before it the bill H. R. 4840 by Mr. Fogarty, calling for a survey of sickness. We are happy to have a statement from Mr. Fogarty at this time. It will be placed in the record at this point.

(The statement is as follows:)

STATEMENT OF JOHN E. FOGARTY, M. C., SECOND DISTRICT OF RHODE ISLAND ON H. R. 4840, SURVEY OF SICKNESS BILL

I appear before this committee in support of H. R. 4840 which was introduced to the Congress by me and which provides for a survey of sickness in the United States.

As chairman of the Appropriations Subcommittee handling the needs of the United States Public Health Service, it has been my privilege to listen to many of the foremost medical experts of this country testify before us. There have been a great many occasions during these hearings when figures on the numbers of cases of one or another chronic disease in this country have been quoted to show the need for particular action. Many times these experts have been forced to estimate figures because of the lack of basic, current statistics. The persons quoting these figures have used what were the best possible estimates available to them. But if you were to trace these figures back to where they originated, nine times out of 10 you would find that they come from the national health survey which was made back in the winter of 1935 and 1936. The survey was at that time, and still is, the best and by far the most comprehensive effort ever made in this country to assess the state of health of our citizens in objective terms.

But conditions change. No one can honestly say that the amount of illness of various types found in that survey is really a true picture of the situation today. At that time we were just emerging from the worst depression in our history; many families were still on relief. Since then we have been through a great war. We have had many advances in medical techniques. New drugs have cut down the illness from many acute communicable disease.

On the other hand, there is some evidence that the amount of illness from the serious chronic diseases is still on the increase. But we don't really know, except from death statistics which tell only a small part of the story. Meanwhile, the average age of our population has increased and other social changes have occurred.

Yet now, 13 years after the national health survey, we are still using the figures obtained that winter to guide us in our decisions on policies involving the Nation's health. Research workers, too, feel the need of new data. In fact everyone who attempts to work in the field of health improvement sooner or later runs into the problem of the lack of adequate data.

Now this bill does not solve all the problems brought about by our lack of up-to-date statistics on illness in the United States. The survey proposed here won't give us all the answers, by any means. For example, it could not give us detailed figures on the amount of illness in the population living in each State in the country. Such a survey would have to be far more costly than the one proposed here. But what it will do is to give us reliable estimates for the country as a whole and for the various age groups, occupation groups, and so forth, based on a representative cross section of our people. And it will do it by methods which, I am told, have been much improved since the national health survey owing to the great advances that have been made in the techniques of measuring the amount of illness. Furthermore, it will do the job at a cost far lower than the cost of the national health survey.

It seems to me that the time has come to get some up-to-date information on the magnitude of the problems we have been and will continue to be spending so much money on. I think that passage of this bill will remedy a long-felt need and I urge your support of it.

Mr. PRIEST. We have also a report from the Federal Security Agency on the Fogarty bill, a favorable report, suggesting an amendment. We have a report from the Comptroller General in which no recommendation is made, and the Secretary of Commerce in which a recommendation for an amendment is made. Without objection they will be included in the record at this point.

(The documents are as follows:)

FEDERAL SECURITY AGENCY,
Washington, June 16, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of May 25, 1949, for a report on H. R. 4840, a bill to provide for a survey of sickness in the United States.

The bill would authorize and direct the Surgeon General of the Public Health Service in the Federal Security Agency (1) to make a survey of the population of the United States by the most reliable means, to determine (*a*) the number, age, sex, ability to work, and usual occupation of persons afflicted with chronic or other disease or injury or handicapping condition; (*b*) the type of disease or injury of each person so afflicted; (*c*) the length of time that each such person has been prevented from carrying on his usual occupation or activities; and (2) to report to the Congress, within 12 months after the date of enactment of the act, the results of the survey. It provides for the Surgeon General, through the Federal Security Administrator, to request the cooperation of State health departments and other Federal, State, and local government agencies, and it authorizes the appropriation of not more than $750,000 to carry out the provisions of the act.

There is no doubt about the need for the type of information that would be provided by the survey proposed in this bill. As is indicated in the preamble to the bill, the most recent national information regarding the prevalence of important chronic diseases is that which was obtained from the national health survey of 1935–36. Those figures have been used over and over again during the intervening years, but their accuracy as a picture of current conditions becomes more uncertain every year. We are, therefore, in full agreement with the objectives of this bill.

It is a desirable feature of the bill that it does not specify the exact means by which the needed information is to be obtained, other than to say that it shall be a survey of the population by the most reliable means. Since the task of measuring the amount of sickness in the population is a difficult one, it is wise, we believe, to leave the details of method to be worked out by experts in this subject matter.

However, for the same reason, the requirement contained in clause (2) of section 1 of the bill, directing the Surgeon General to report the results of the survey to the Congress within 12 months after the date of enactment of this act, appears to allow too little time for the task to be done with the care that will be necessary. For example, it would be desirable to test out on a small scale the plan decided upon in advance of the full-scale survey, and careful preliminary training of interviewers is an essential part of the work. We, therefore, recommend that the time within which a report must be made to Congress be extended at least to 2 years and preferably to 30 months.

While the method of conducting the survey is left to the discretion of the Surgeon General, the items of information relating to the afflicted person and his family have been specifically listed in section 1, clause (1). In order to make the survey serve the purposes mentioned in the preamble, especially item 4, concerned with an evaluation of the impact of long illness upon the economic status of families, it would probably be necessary to include additional economic items. For this reason we suggest that the language of section 1, clause (1), be broadened to permit the Surgeon General more discretion in selecting the particular items of information that would be collected and analyzed. This could be done by adding after the word "activities;" in line 12 of page 2 the following: "and (d) other related information regarding each such person and his family."

With regard to the sum of $750,000 that would be authorized to be appropriated to carry out the survey, it is difficult to say whether this sum would or would not be sufficient. A great deal depends upon the size of survey that would be required to give results in the desired degree of detail.

In this connection it would be well to refer here to a report which we recently made to the chairman of the Committee on Post Office and Civil Service of the House of Representatives on H. R. 3937, a bill to provide for a survey of physically handicapped citizens. There is a good deal of overlapping in the objectives of these two bills, and many of the comments made by this Agency in reporting on that bill apply equally well to this one, though the features originally present in H. R. 3937 which would have caused particular difficulty are not present in H. R. 4840. However, H. R. 3937 specifically called for the number, age, and location of physically handicapped citizens. In view of the need expressed there for the geographical distribution of handicapped persons, the very much larger sum of money authorized ($5,000,000) seemed none too much. This is due to the fact that when reliable statistics for each of a number of sections of the country are required, almost as large a survey is needed for each section as is needed to give dependable figures for the United States as a whole.

The present bill, H. R. 4840, proposes only to estimate the number, age, and so forth of afflicted persons (as described in sec. 1, clause (1)) for the United States, as a whole. Nevertheless, some doubt has been expressed by experts in this Agency as to whether the sum of $750,000 would be adequate. However, the consensus seemed to be that it would be sufficient if very detailed data will not be required from the survey.

We would therefore recommend that the bill, modified as suggested above, be enacted by the Congress.

Time has not permitted us to obtain advice from the Bureau of the Budget as to the relationship of this bill to the program of the President.

Sincerely yours,

J. Donald Kingsley,
Acting Administrator.

General Accounting Office,
Washington, D. C., June 15, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

My Dear Mr. Chairman: Further reference is made to your letter of May 25, 1949, acknowledged by telephone May 27, requesting a report on H. R. 4840, Eighty-first Congress, entitled "A bill to provide for a survey of sickness in the United States."

The bill would authorize and direct the Surgeon General of the Public Health Service to make a survey of the population of the United States to determine the number, occupation, etc., of persons afflicted with any disease or handicapping condition, the type of disease of each such person and the effect of such disease, etc., on his occupation or activities, and to report to the Congress within 12 months after enactment of the act. Section 2 of the bill provides that State health departments and other Federal, State, and local government agencies shall be requested to cooperate in carrying out the provisions of the act and that the Surgeon General may consult with nongovernmental associations and experts in planning the survey and preparing the report. Section 3 would authorize the appropriation of a maximum of $750,000 to carry out the provisions of the act.

Senate Resolution 249, Eightieth Congress, which was agreed to by the Senate on June 12, 1948, directed the Senate Committee on Labor and Public Welfare, through the said committee's Subcommittee on Health, to study the health problems of the Nation and legislative proposals relating thereto and to report the results of such study to the Senate not later than March 15, 1949. It is understood informally that such report has not yet been made. However, a discussion of the matter generally is contained in Senate Report No. 1571, Eightieth Congress, accompanying Senate Resolution 249, above referred to.

Other than as above set out, this Office has no information as to the need or desirability of the proposed legislation; and, therefore, I make no recommendation with respect to the enactment of H. R. 4840.

Pursuant to your request, two carbon copies of this report are enclosed herewith.

Sincerely yours,

LINDSAY WARREN,
Comptroller General of the United States.

DEPARTMENT OF COMMERCE,
Washington, D. C., June 22, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is written in reply to your request of May 25, 1949, for comments on H. R. 4840, a bill to provide for a survey of sickness in the United States.

I have no opinion as to whether there is a need for the securing of such data with regard to persons suffering disabling diseases, injuries, and handicapping conditions.

If the Congress determines that such a need does exist, I should like to suggest that the word "citizens" used in paragraph 2 of the preamble be changed to the word "inhabitants." Otherwise, a limitation would be placed on the coverage of the survey, and the survey would be complicated by the requirement that only citizens be enumerated.

The bill provides for the authorization of an appropriation not to exceed $750,000 for the purposes of this survey. If the Congress decides that this legislation should be enacted, I suggest that this amount be reexamined with respect to its adequacy in terms of the nature and scope of the information desired.

Subject to the above comments, I have no objection to the enactment of this proposed legislation. Due to the urgency of the committee's request, I have not had an opportunity to obtain the advice of the Bureau of the Budget as to whether or not there would be any objection to the submission of this report.

Sincerely yours,

CHARLES SAWYER,
Secretary of Commerce.

Mr. PRIEST. That concludes the hearings for today. The committee will stand adjourned until Wednesday, June 29.

(At 12 noon, the committee recessed to reconvene Wednesday, June 29, 1949.)

#25C

NATIONAL HEALTH PLAN

WEDNESDAY, JUNE 29, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The committee will come to order.

Before the committee today are quite a number of individual bills, all proposing amendments to the Hospital Construction Act.

There is also title III in the omnibus bills, 4312 and 4313, which propose amendments to the Hospital Construction Act; and titles of a number of identical bills, such as H. R. 4918.

The reporter will include at this point in the record the number and sponsors of all of the individual bills proposing the amendments to the act.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills): National health, with respect to title III, hospital survey and construction amendments.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills): National health.

H. R. 323, by Mr. Bartlett, and H. R. 4771, by Mr. Mitchell: To amend section 1 of the act entitled "An act to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals" (Public Law 830, 80th Cong.).

H. R. 991, by Mr. Keefe: To amend the Public Health Service Act to provide assistance for the construction of hospitals furnishing domiciliary care.

H. R. 1721, by Mr. Merrow: To amend the Public Health Service Act to authorize the payment of prior construction costs of certain hospitals approved as projects under such act.

H. R. 2175, by Mr. Grant: To amend sections 613, 624, 625, and 631 of the Hospital Survey and Construction Act (60 Stat. 1042, 1045–1047).

H. R. 2176, by Mr. Grant; H. R. 2567, by Mrs. Douglas; H. R. 3025, by Mr. Patten; H. R. 3515, by Mr. Rains; and H. R. 3737, by Mr. Bennett, of Florida: To amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act) to extend its duration and provide greater financial assistance in the construction of hospitals, and for other purposes.

H. R. 3070, by Mr. Werdel: To amend the Hospital Survey and Construction Act.

H. R. 4126, by Mr. Lemke: To amend the Public Health Service Act to increase the Federal payments for the construction of hospitals, and for other purposes.

H. R. 4215, by Mr. Deane: To amend title VI of the Public Health Service Act to provide additional Federal aid in the construction of hospitals, to provide Federal aid in the maintenance and operation of hospitals, and for other purposes.

H. R. 4763, by Mr. Poulson, and H. R. 4944, by Mr. Angell: To amend Public Law 725, Seventy-ninth Congress, section 624.

Mr. PRIEST. Without objection, we will insert a report from the Department of the Interior.

(The report is as follows:)

DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington, D. C., July 8, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

MY DEAR MR. CROSSER: This is in reply to your request for this Department's views on H. R. 323 and H. R. 4771, identical bills, to amend section 1 of the act entitled "An act to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals" (Public Law 830, 80th Cong.).

The bills would amend section 1 of Public Law 830 (80th Cong., 2d sess.) so as to provide for a minimum allotment of $250,000 to each State for the construction of hospitals under section 624 of the Public Health Service Act (60 Stat. 1040).

This Department is concerned with allocations under the fund to our Territories and possessions. In view of the high construction costs in our Territories, additional Federal assistance is required to meet the urgent need for additional hospital facilities. This is especially true in Alaska. The Territory of Alaska has initiated and is conducting an intensive tuberculosis control and hospital program to combat a tragically high tuberculosis death rate nine times that of the continental United States. This program is handicapped by the woefully inadequate and overburdened medical and hospital facilities in Alaska. In addition, there are no facilities in the Territory to take care of those of its residents, approximately 340, who have been legally adjudged insane. The health of the people of Alaska and the facilities which are required to deal with this problem are of concern to the entire Nation, particularly because of the national interest in the development and settlement of Alaska.

For the foregoing reasons I strongly urge your committee to take favorable action on this legislation.

In view of the imminent consideration of these bills by your committee, this report has not been submitted to the Bureau of the Budget for its consideration; therefore, I am unable to state the relationship of the views expressed herein to the program of the President.

Sincerely yours,

OSCAR L. CHAPMAN,
Acting Secretary of the Interior.

Mr. PRIEST. We have quite a number of the Members of the House scheduled to appear as witnesses this morning. I see our colleague, Mr. Lemke, is present. We will be glad to hear you, Mr. Lemke.

Mr. O'HARA. Mr. Chairman, may I just before Mr. Lemke goes on, if Mr. Lemke also will pardon me, offer for the record a statement by our colleague, Representative Bishop, of Illinois. He has asked me to file a statement for the record for him in the interest of House bills 2176, 3025, and 2567, and also H. R. 3737 introduced by Mr. Bennett, of Florida.

I ask unanimous consent, Mr. Chairman, that that statement might be filed at this time and inserted in some appropriate point in the record.

Mr. Bishop is unable to be here this morning, and has asked me to file this statement for him.

Mr. PRIEST. Without objection, it may be made a part of the record at this point.

(The statement referred to is as follows:)

STATEMENT OF REPRESENTATIVE C. W. BISHOP OF ILLINOIS

The Anna (Ill.) City Hospital for which a $387,325 grant was approved before January 1, 1949, and the St. Clements Hospital at Red Bud, Ill., are two projects in my congressional district which will be denied the benefits of the more liberal hospital construction grants proposed by House bills 2176, 2567, 3025, and Senate bill 614.

H. R. 3737, introduced by Mr. Bennett, of Florida, amends the Hospital Survey and Construction Act (title VI of the Public Health Act) to extend its duration and provide greater financial assistance in the construction of hospitals, and for other purposes, and if enacted will correct this discrimination against projects approved before January 1, 1949, including the Anna City Hospital and the St. Clements Hospital at Red Bud, Ill.

Mr. PRIEST. The Chair is in receipt this morning also of a telegram from the gentleman from Vermont, Mr. Plumley, who was scheduled to testify before us, but was unable to be here, and desires that his telegram be inserted in the record.

(The telegram referred to is as follows:)

NORTHFIELD, VT., *June 29, 1949.*

HON. PERCY PRIEST, M. C.,
House Office Building, Washington, D. C.:

Cannot get back in time to appear before your subcommittee. Please advise subcommittee that I urge them to give favorable consideration to H. R. 3737. It relieves the Congress of discriminating against those hospitals for which grants were approved before January 1, 1949. I am sure I did not vote to discriminate against any hospital and if the effect of the law is such as to discriminate, which it obviously is, then the act of date, August 13, 1946, should be amended as proposed. The necessity for and the fairness of the proposed amendments are obvious.

CHARLES A. PLUMLEY, M. C.

Mr. PRIEST. Mr. Lemke.

STATEMENT OF HON. WILLIAM LEMKE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. LEMKE. Mr. Chairman and members of the committee, I introduced H. R. 4126 to amend the Public Health Service Act to increase the Federal payment for the construction of hospitals from 33⅓ to 50 percent.

Now that we are about to pass the Housing Act for a small percentage of our people, I feel that it is just as important or more important to have hospitalization for the ailing. Under the present Public Health Service Act, many local communities throughout the Nation have, or are constructing hospitals. The showing has been remarkable but many of these communities find themselves in financial difficulties to complete or start building some of these hospitals.

Since health affects the Nation as a whole, I am sure there can be no great objection to the Federal Government going 50–50 with the local communities in this worthy project. I feel that any argument on that part of that is superfluous.

I wish to thank the committee for its consideration of my bill, H. R. 4126, in connection with numerous other bills on the same subject, and I may state, Mr. Chairman, that I have no objection to any of these bills, whichever one you feel should be enacted and meets the present requirements.

I thank the committee.

Mr. Priest. Mr. Lemke, various of these bills propose different amounts. Your bill, as I understand it, is directed specifically to the proportion of Federal funds.

Mr. Lemke. That is correct.

Mr. Priest. And increasing those from 33⅓ to 50 percent. Is that correct?

Mr. Lemke. That is correct.

Mr. Priest. Are there any questions?

Mr. O'Hara. Yes, Mr. Chairman.

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. Mr. Lemke, I have not had a chance to study your bill. What is the contribution made by the local and State interests? Is there any reference to that at all?

Mr. Lemke. Not as to the locality, but the locality takes care of 50 percent.

In my State, they have built a very large number, practically in every county there is one or two of these hospitals either under construction or proposed to be built, and I am sure that they need an increase over 33⅓ percent.

Mr. O'Hara. One of the difficulties, Mr. Lemke, that I personally noted in my district in connection with two of the hospitals which have been built under this program was the terrific cost; the cost of the construction of the hospitals ran far over what the estimates originally were, and they have had a hard time raising the money. I presume building construction costs may go down and that will relieve some of the load which has been rather hard for the local municipalities to carry.

Mr. Lemke. That is correct; but the cost has not decreased very much as yet. Labor is just the same. Material, in which labor is included, for instance, is just the same.

When we speak of the cost of building, it is not the immediate construction that gives you the increase—and I am not objecting to the increases for labor, because I know that labor is also getting only 30 cent dollars, that is the purchasing power of 30 cents; but you have got to begin with the brick when it is made. There is an increase there, where it is made, and there are increases all the way up the line, so that when you get to the real construction, you will find that it still is about three times as high as it was in 1935, 1936, 1937, 1938 and 1939.

Mr. O'Hara. Well, the point I am making is with reference to the cost, Mr. Lemke, and it is a fact that some of the municipalities are up to the limit of their authorized bonded indebtedness, and there is that problem in some of these cities where hospitals are needed very badly.

Mr. Lemke. That is especially true in your and my State.

Mr. O'Hara. Yes; that is true.

Mr. LEMKE. Because the municipalities are limited by law, and they are right up against it, and there is where they need assistance.

Now, some bills ask as high as 75 percent from the Federal Government. Of course, I have no objection to that, but I thought I would be more modest and stay with 50 percent.

Mr. O'HARA. You sometimes think that there is a limit to the bottom of the barrel called Uncle Sam, too?

Mr. LEMKE. I realize that.

Mr. PRIEST. Are there any further questions? If not, we thank you, Mr. Lemke.

Mr. LEMKE. I wish to thank the committee again.

Mr. PRIEST. Mr. Bennett, of Florida.

STATEMENT OF HON. CHARLES E. BENNETT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. BENNETT. Mr. Chairman and gentlemen of the committee, I deeply appreciate the courtesy of your allowing me to come here to testify, and I know you have many people here, and I will be very brief. I have a rather full formal statement to be filed, and I will now just try to give you briefly my feelings about it.

I have introduced H. R. 3737.

Mr. Herlong, of Florida, is here with me, and we have talked this over, and he has said that he would let me represent the Florida delegation, because he knows your time is crowded.

Mr. PRIEST. Very well. As fine as that delegation is, I am sure it will be very well represented by Mr. Bennett.

Mr. BENNETT. Thank you.

Mr. O'HARA. Mr. Chairman.

Mr. PRIEST. Mr. O'Hara.

Mr. O'HARA. I do not know whether you were here, Mr. Bennett, when I filed a statement by our colleague, Mr. Bishop, of Illinois. In that statement he expresses interest in your bill, also.

Mr. BENNETT. Thank you, sir.

H. R. 3737 does a number of things. I wish to stress some things which have been left out of the general discussion about hospital construction, but this bill provides for raising the amount of money from $75,000,000 to $150,000,000 annually for hospital construction.

The testimony on that I am sure will be quite full from experts in the field and it is not my intention to dwell particularly on that field, because before this hearing is over, you will have heard representatives on that particular subject, and my brief gives plenty on it. My statement here will be primarily designed to show the necessity for having a long-time plan for the purpose of proper planning in the hospital construction work, a sufficiently long time that proper plans can be made for all of the hospitals that are possible for us to construct under the program. Secondly, and perhaps I should say primarily, as far as importance is concerned, I wish to stress the necessity of a retroactive feature in the bill. Some of the bills which have been introduced have not made any provision for a retroactive feature. I would like first to point out to the committee that this program is a new program. Although it was started in 1946, at that time they had no particular material to tell just what the hospital needs were in the communities. The estimate in connection with the bill then passed was that it would provide for about 25 percent of the needs of hospitalization in the country, in the construction of hospitals. Since that time, construction costs have gone up, and it has been found that the original survey in connection with the bill enacted at that time, as drawn in 1946, will probably give us about 10 percent of the needed additional hospital facilities in the United States.

The situation we are confronted with is that we need to extend the duration of time for a sufficient period to allow the people that fall in the lower categories, the B and C categories, to have some chance of looking forward to some development. If we just do this thing on a year to year basis we are going to find that long range planning is not going to be possible. Also, we can see the necessity of having the retroactive feature, because of the actual circumstances and what took place. What took place under the 1946 act was, first of all, that they had these surveys, and the surveys consumed the greater part of 1946 and all of 1947, and that brings us down to the latter part of 1948 before any actual hospitals were started to be constructed. Only 10 of them were constructed, as I understand, under this program prior to January 1, 1949. One hundred ninety-eight were approved before January 1949.

Mr. O'HARA. Is that in the State of Florida?

Mr. BENNETT of Florida. No; I am talking about all over the United States.

Mr. O'HARA. That is, all over the United States?

Mr. BENNETT of Florida. That is correct.

Mr. O'HARA. We must have an unusually high record in my district. I think that we have three.

Mr. BENNETT of Florida. That is probably true. This thing has been a very spotty program, because the people who were really industrious, as the people in your State and mine were—they went out and took a real initiative.

I understand that there has been a terrific impetus since January 1, 1949, and that now projects are getting under way.

Our plan is to change the allotment from 33⅓ percent flat percentage for all to a sliding scale, depending upon the need of the particular States.

If we do not have the retroactive feature in it, we are going to arrive at a situation where just because a particular deadline is set, it is going to penalize these people who have already gotten under way and who most need the help; and this under a program which is new and just now getting really started.

The construction in many cases will not have anywhere near been completed. Nevertheless, we will have solidified the thing at 33⅓ percent for those people who actually took the initiative and had the courage to go ahead, float the bonds, or do whatever it took to get the thing under way.

Now, if the thing that we had were over a period of years in the past and many hospitals had been built under it, and in which a lot of definitive work had been done in the past, of a sizable nature, that would be an entirely different situation. We do not have that.

This is practically a new program, so it seems to me that it is only fair and only just to have a retroactive feature in it. This bill I have introduced, H. R. 3737, takes care of that retroactive feature.

Now, I do want to live up to my promise and not to take too long. There are a few clerical errors in H. R. 3737 which I would like to correct in the record at this time.

I think that these amendments, which are purely questions of correcting errors, in the print, should be put into the record.

On page 3, strike out "623" in line 1 and insert in lieu thereof "625."

It refers to the wrong section. That is the trouble there.

On page 5 strike out "(a)" in line 21.

That last correction is for the purpose of bringing under a particular provision all of the particular section referred to, to wit, section 3. If that is not done, the Federal Government will lose money. It is a clerical error and not a thing designed to get more money for the States. It is not a substantive correction and deals with a typographical error.

Would anyone like to ask me any questions about this matter?

Mr. O'Hara. Mr. Chairman, may I ask a question?

Mr. Priest. Mr. O'Hara.

Mr. O'Hara. I did not understand that the 10 constructed hospitals you spoke of were prior to January 1.

Mr. Bennett of Florida. Yes, sir.

Mr. O'Hara. I think probably only one of those in my district was completed by that time. The other two, I think, were subsequent to that time.

Mr. Bennett of Florida. I think that the record will show that where the hospitals were built they were greatly needed and were in localities where the people were least able to take care of their own situation. In places where they were greatly needed, had been needed for a long time, the people got in and said that they were going to do something under this program, and they did something. Now, if we do not make this retroactive, it is going to penalize those people who need it the most.

Mr. Priest. Are there any other questions?

Mr. Bennett of Florida. I have asked for inclusion with my statement here, certain memorials from the Medical Association in the State of Florida, and others. I have turned them over to the clerk.

Mr. Priest. Thank you, Mr. Bennett.

You feel, along with any possible other amendments that might be reported by the committee, that the retroactive feature is one of great importance, in your opinion?

Mr. Bennett of Florida. I think it is tremendously important and is the only way that we can really be fair and do equity in the program.

Mr. Bennett of Michigan. Mr. Chairman.

Mr. Priest. Mr. Bennett.

Mr. Bennett of Michigan. I have just been looking at this section, this provision in H. R. 4312. Have you read that?

Mr. Bennett of Florida. I have read it. I do not have it in mind at the moment.

Mr. Bennett of Michigan. It provides that no such estimates, referring to Federal grants, shall provide for the Federal share, more than 66⅔ percent or less than 33⅓ percent of the cost of construction of any project.

That evidently would leave it up to the Surgeon General to determine what the Federal share will be, within those limits.

Mr. BENNETT of Florida. It may be in that particular bill.

Mr. BENNETT of Michigan. Are you asking for any such a provision in your bill?

Mr. BENNETT of Florida. No. My bill provides for a percentage already set up in the basic law which has never been applicable, however, except in a limited field.

My bill makes it applicable as to the general distribution of the funds.

The percentage has already been set up in the law, but we just want to use it in the same way that it is going to be used in 3737. It is already set up in the original Hill bill.

You might ask: What is going to happen to this money in connection with the retroactive feature?

This record shows, and my formal statement will deal with the facts in detail, that only about 25 percent of the needs, the hospital needs of these particular areas, is being met in any way. They all had to cut way back in their desire to meet their great needs. So, the money would be used first of all to catch up with the construction and make it somewhere near equitable. Where the hospital has been constructed to meet all needs—well, if it went to retire some of the bonds, that would be equitable. In most cases it will never go to retire the local bonds. It will be chiefly for the purpose of making it the kind of a hospital that they ought to have, or ought to have had in the first place, or something near it.

Mr. PRIEST. Are there any other questions? If not, we thank you very much for your statement, Mr. Bennett.

Mr. BENNETT of Florida. Thank you.

(The statements above referred to are as follows:)

STATEMENT OF CONGRESSMAN CHARLES E. BENNETT ON H. R. 3737 AND OTHER BILLS BEING CONSIDERED, ALL OF WHICH PROPOSE TO AMEND THE HOSPITAL SURVEY AND CONSTRUCTION ACT

I sincerely appreciate this opportunity to appear before you in support of H. R. 3737, to amend the Hill-Burton Act on hospital and health-center construction.

In Florida, under the Hill-Burton Act, we now have grants approved for 17 hospital and health-center projects, representing a construction program of approximately $14,000,000.

Of these 17 projects, 1 has been completed and 9 are now under construction, representing approximately $11,000,000 in contracts. All of these projects are in A and higher B priority areas.

I know of no Federal-grant program that is meeting a greater need and has been received more enthusiastically by the people of Florida than this program. Both the professional groups and the political subdivisions of Florida, including the Florida Hospital Association and the Florida Medical Association, have enthusiastically endorsed the purposes of the program and the method of administration established by this act.

During the course of the recent Senate committee hearings on hospital construction, several competent authorities stressed the desirability of (1) increasing the annual contractual-obligation authority of the Surgeon General and (2) providing funds to make possible research experiments and demonstrations for the purpose of determining the possibilities of coordinating the services of hospitals. I will comment only briefly on these two phases of the bills now being considered because I understand these same national authorities are to appear before this subcommittee.

When the present act was passed in 1946, the 5-year program as authorized was expected to meet approximately 25 percent of the Nation's hospital needs. Little specific information was then available as to the hospital needs of the Nation. After the States had completed their hospital survey, it became evident that the hospital needs of the Nation were greater than had been anticipated.

The greater part of 1947 and the first half of 1948 were consumed by the States in conducting these surveys and preparing their State plans as required by the act. By the summer of 1948 when the States were ready to start building hospitals it was found that construction costs had increased considerably since the passage of the act. Because the hospital needs of the Nation were greater than had been anticipated in 1946, and because building costs have increased considerably since 1946, it now appears that only approximately 10 percent of the hospital needs of the Nation will be met under the provisions of the present act, according to the best estimates available to me. If our people are to have adequate hospital facilities within the foreseeable future, we must substantially increase the annual contractual-obligation authority of the Surgeon General. I know that this point will be developed in great detail by the testimony of the United States Public Health Service, the American Hospital Association, and others.

I will restrict my remarks primarily to discussion of (1) the importance of extending the duration of the act for a sufficient period, and (2) the importance of making the newly recommended basis of allotments retroactive and applicable to projects approved heretofore.

First, little attention has been given to the importance of extending the duration of the act over a sufficient period of time to allow effective advanced planning.

Under the present act it now appears that there will be sufficient funds to entertain applications from only A and high B priority areas in the State of Florida. There is a real need for additional hospital beds in our low B and C priority areas; however, hospital groups in these lower-priority areas, under the conditions of the present act, cannot plan hospitals or additions of existing hospitals with any degree of certainty. If the act is extended for a period of years we can give our lower-priority areas some assurance of financial assistance, which assurance would enable prospective applicants in these areas to start planning now for projects expected to be placed under construction several years from now. May I remind the committee that usually from 1 to 2 years or more pass between the time a community definitely decides to build a hospital until the hospital is placed under construction. Bond elections must be held, bond issues validated, a site must be selected, financial studies must be made, preliminary plans must be prepared and studied, and second-stage drawings and outline specifications thoroughly analyzed before the architect starts the long and laborious task of preparing detailed working drawings and contract specifications. After the final plans and specifications are thoroughly checked and construction estimates prepared, the architect must then advertise for bids and allow prospective bidders from 45 to 90 days to study the plans and specifications before bids are received. If, when bids are received, it is found that the cost of the proposed structure is in excess of available funds, the architect must rework his plans and specifications to reduce the cost of the project. Each step requires time.

House bills 3737, 2176, 2567, and 3025 propose to extend the program 4 years. Title III of H. R. 4312 and H. R. 4313 would extend the program to June 30, 1957. The longer extension proposed by H. R. 4315 and H. R. 4313 allows for more advanced planning.

The second point which I believe did not receive the attention its importance deserves in the discussions before the Senate subcommittee is the determination of the effective date for the increased grant percentage proposed by House bills 3737, 2176, 2567, 3025, and title III of House bills 4312 and 4313.

According to House bills 2176, 2567, and 3025 all grants approved after January 1, 1949, would be for that portion of the project cost equivalent to the State's allotment percentage. The allotment percentage of most States is greater than 33.33. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. As of January 1, 1949, construction grants had been approved for approximately 525 projects throughout the Nation. Of these 525 projects only 188 were under construction and only 10 actually completed as of January 1. According to the provisions of these three bills grants for the 10 completed projects and those 188 projects which received final approval for the letting of contracts before January 1 would remain pegged at one-third of construction costs; and, depending upon the interpretation which may be given by the general conusel of the Public Health Service, the projects which had received preliminary approval before January 1, 1949, but which had not received final approval for the letting of contracts might also be placed in the same category. This would mean that communities which have exercised the greatest courage and initiative in creating a definite hospital program, floating bond issues, preparing plans, and which have placed their hospitals under construction at an early date would be penalized; and those communities which have exercised less courage and initiative and whose hospitals went under construction after January 1 or will not go under construction until some future date would receive grants in excess of one-third of construction costs.

It is felt most important that the increased grant percentage proposed by House bills 2176, 2567, 3025, and others be made retroactive to the beginning of the program in order that all communities building hospitals might share equally in the benefits of the program. If this were an old program, and if many hospitals had been completed under the provisions of the present act, it would be unreasonable to request that the new allotment percentage be made retroactive. However, since the program is so new with only 198 projects actually placed under construction throughout the Nation and only 10 projects completed in the entire United States before January 1, it appears only reasonable that the increased grant percentage be made applicable to all approved projects.

Should the Congress fail to make the proposed increased grant percentage applicable to those 198 projects approved before January 1 it would not only penalize these applicants for their courage and initiative in securing early approval but would also defeat the stated purposes of the program, the purposes being to secure a more even distribution of hospital care throughout the Nation by encouraging and assisting in the construction of "the necessary physical facilities for furnishing adequate hospitals, clinics, and similar services to all their people." This contention is substantiated by an analysis of the 198 projects approved before January 1, the grants for which projects would be pegged at one-third of construction costs by the provisions of H. R. 3176, H. R. 2567, H. R. 3025, and several other bills now being considered.

An analysis of these 198 projects approved for construction contracts before January 1, 1949, reveals the following:

(1) Of these 198 projects, only 10 small projects with grants averaging less than $71,000 each were completed before January 1, 1949.

(2) These 198 projects are distributed through 42 States.

(3) Over 80 percent of these 198 projects were approved during the last 6 months of 1948, and contracts were let when building costs were at a peak.

(4) These 198 projects were predominantly small rural general hospitals.

(5) These 198 projects were predominantly in A and high B priority areas, that is, those areas in greatest need of hospitals.

(6) The applicant's two-thirds of the construction costs of these 198 projects were raised predominantly through the issuance of bonds, revenue certificates, and other types of indebtedness.

(7) Most important of all, the beds provided by these 198 projects approved before January 1, 1949, will provide only approximately one-fourth of the minimum bed needs in these A and high B priority areas, as defined by the State plans of the 42 States in which these early projects are located.

These early applicants who have raised through public subscription, the issuance of bonds, revenue certificates, and other types of indebtedness the two-thirds of the cost of planning, constructing, and equipping these small hospitals have, in most instances, depleted their financial resources for many years to come. The size and design of the hospitals which they are building or have built were not determined by the needs of the community but by the ability of the community to raise two-thirds of construction cost.

If the proposed liberalized grant percentage is not made retroactive, these 198 areas who have strained their financial resources to build small hospitals which meet only a fraction of their admitted minimum hospital needs will be "frozen" with their small, inadequate hospitals for many years. Few will be able to raise additional local funds to qualify for a second grant for enlarging their hospitals even under the liberalized grant percentage. However, if the effective date for the more liberal grant percentages is made retroactive these applicants will receive additional funds which may be used for enlarging these small hospitals to more nearly meet their minimum community needs. They would then have in proportion to local funds involved, a hospital of a size and design comparable to those communities whose final applications were approved, or will be approved, after the arbitrary date January 1, 1949.

H. R. 3737 corrects this discrimination against projects approved before January 1 by stating August 13, 1946 (the date on which the present act became law), as the effective date for the more liberal grant percentages. This will allow the projects approved before January 1 to participate in the more liberal grants, and thereby construct nursing wings to these small hospitals in order that they might more nearly meet the minimum hospital needs of the communities involved. These communities would then have in proportion to local funds involved hospitals of a size and design comparable to the communities whose final applications will be approved after January 1.

Mr. Chairman, may I give the committee several examples to show exactly what I mean?

1. The only project now completed in Florida is the Suwannee County Hospital located in Live Oak. According to the nationally accepted formula (2½ beds per thousand population served) for minimum hosiptal needs, a rural area such as is served by the Suwannee County Hospital should have a 70-bed hospital. After several years of careful planning and by straining their financial resources, the people of Suwannee County were able to raise only two-thirds of the cost of building a 36-bed hospital which provides this area with approximately 1.3 beds per thousand population or approximately one-half of the admitted hospital needs of the area. Furthermore, in order to supply two-thirds of the cost of constructing this small hospital it was necessary to delete from the original plans provisions for labor rooms, minor surgery, a nurses' residence and other needed facilities. At present, the Suwannee County Hospital is finding it necessary to rent at a cost of $125 per month a residence to house their nursing and technical staff.

Had the grant for this project been for that proportion of construction costs now proposed by the several House bills now being considered, the people of Suwannee County would have been able to construct a hospital of a more adequate size and design. If H. R. 3737 is enacted, additional funds will be available to construct the much needed facilities which were deleted from the original plans.

2. *South Florida Crippled Children's Hospital, Coral Gables.*—For the past 8 years the South Florida Children's Hospital Corp. has been raising funds for the construction of a much needed orthopedic hospital for the children of southeast Florida. When detailed estimates were received late last year for the construction of this hospital, it was evident that the funds of the hospital, plus the matching funds provided under the present act, were insufficient to meet the cost of building and equipping the hospital as planned. As a result, it was necessary to eliminate an entire 22-bed nursing unit intended for the treatment of poliomyelitis. Omission of this nursing unit reduced the capacity from 96 to 74 beds. Should the provisions of H. R. 3737 be enacted, the owners propose to complete the hospital as originally planned including the nursing unit for treatment of poliomyelitis.

3. *Southeast Florida Sanatorium, Lantana, Fla.*—The 1947 legislature of Florida appropriated 2½ million dollars to be used by the State tuberculosis board in matching Federal funds for the construction of two critically needed tuberculosis sanatoria. When bids were received for a 400-bed sanatorium now under construction at Lantana, it became evident that the State tuberculosis board would have only sufficient funds to meet two-thirds of the cost of building and equipping this one sanatorium. This sanatorium, when completed, together with the existing sanatorium at Orlando, will provide less than one-half of the beds needed to care for tubercular patients in Florida.

Should the provisions of H. R. 3737 be enacted, thereby requiring the State tuberculosis board to supply only 42½ percent of the construction costs of this hospital instead of the 66⅔ percent as required by the present act, the board would then have a sufficient balance of unobligated funds in its State appropriation to match Federal funds on the basis of the proposed new grant percentage to construct a new 200-bed sanatorium in west Florida which is the next project on the established construction program of the State tuberculosis board.

4. *American Legion Hospital for Crippled Children, St. Petersburg.* For over 10 years the American Legion Hospital for Crippled Children, a nonprofit corporation, has been accumulating funds for the purpose of constructing a modern fireproof hospital to replace the present two-story, wood frame, converted residence which they have been operating as a crippled children's hospital for the past 20 years. Because of the nature of the patients served by this hospital, this two-story frame structure has been considered and declared a most serious fire hazard.

When bids were received for the construction of this new hospital, the corporation found that they did not have sufficient funds to defray two-thirds of the cost of constructing and equipping the hospital as planned. As a result, it has been necessary by three series of addenda to the specifications to eliminate facilities both necessary and desirable for the effective operation of a children's hospital to the extent of approximately $70,000 in order that a construction contract might be let. Actual construction has just been started. If the provisions of H. R. 3737 are enacted the facilities which have been deleted from the construction contract could be reinstated and the hospital completed as originally planned.

5. *Florida A. and M. College hospital and school for nurses.*—The construction of this project is most important to all Florida hospitals in order that we might have a continuous supply of well-trained Negro nurses for the care of Negro patients. When bids were received for the construction of this hospital and nursing school it was found that sufficient funds were not available to defray two-thirds of the cost of the project. As a result, Dr. William Gray, president of A. and M. College for Negroes, representing the faculty and study body, asked the State Board of Control to approve the issuance of revenue certificates to be retired by an infirmary fee which Dr. Gray proposed be levied against all students at A. and M. College for the next 20 years. This infirmary fee, when added to other existing fees, will be a real burden on the students of the A. and M. College. The project was finally approved and placed under construction only a few days before January 1, 1949. According to the provisions of House bills 2176, 2567, and 3025 had this project been approved and placed under construction after January 1, 1949, the issuance of these revenue certificates and the assessment of student fees would not have been necessary. Should the provisions of H. R. 3737 be enacted it will not be necessary to execute the revenue certificates as proposed.

6. *Bay County Hospital, Panama City.*—Panama City is primarily a "paper mill" community, the population of which has quadrupled during the past 20 years. Since 1940 the population of this community has more than doubled primarily as a result of commercial and service activities during the war. It has been served by 3 small hospitals totaling less than 65 beds, 2 of which are converted frame residence buildings. For the past 7 years the people of Bay County have been trying to construct a community hospital. A 100-bed hospital was designed immediately before the war. After the war the cost estimates for this 100-bed hospital had increased to such an extent, it was found impossible to raise sufficient funds to place the project under construction. New plans were prepared for a 60-bed hospital so designed that two 30-bed wings could be added at a later date. When bids were received on this 60-bed hospital it was necessary that the board of county commissioners obligate over $70,000 of their general county operating funds for the next 3 years in addition to a 20-year bond issue in order to meet two-thirds of construction costs.

The population of this hospital service area is over 43,000 persons. To meet the minimum general hospital requirements of the area would require 173 general hospital beds. Because two of the small hospitals have recently been closed this community will have upon the completion of the community hospital now under construction only approximately two beds per thousand population or approximately one-half of their minimum hospital needs.

If H. R. 3737 is enacted a 30-bed wing and a most necessary nurses residence can be added immediately. This community would then have in proportion to local funds involved a hospital of a size and design comparable to those communities whose applications for grant assistance are approved after January 1, 1949.

I hope that a study of these specific examples will impress the committee with the importance of making the new grant percentages applicable to all projects in order that all communities building hospitals under this program may share equally in the benefits of the program.

Florida is not the only State concerned by the effective date for the proposed new grant percentages. Forty-two States had projects approved and under construction before January 1, 1949, representing approved grants of over $30,000,000. The Public Health Service has estimated that it would require approximately $23,000,000 to adjust all grants approved before January 1, 1949, to an amount equivalent to the State's respective allotment percentage. However, less than $23,000,000 would be required should the Congress choose to limit grants to a maximum of two-thirds of project costs.

Mr. Chairman, with your permission I would like to insert into the record a copy of a resolution adopted by the Florida Hospital Association, a resolution adopted by the board of governors of the Florida Medical Association, a memorial adopted by the Florida legislature, and a resolution adopted by the Southeastern Hospital Conference, all of which support the testimony that I have given to you today.

Mr. Chairman, I earnestly recommend to the committee the provisions of H. R. 3737.

Thank you, Mr. Chairman.

Memorial to the Congress of the United States Requesting That the Provisions of S. 614 of the Eighty-first Congress Be Enacted Into Law With the Amendments Dated March 1 Proposed Jointly by the Two United States Senators From Florida

Whereas the Seventy-ninth Congress, through the provisions of the Federal Hospital Survey and Construction Act, established a national program to assist the several States to inventory their existing hospitals, define their hospital needs, and formulate State plans for the construction of needed new hospitals; and

Whereas through this program grants have been approved for one-third of the cost of planning, constructing, and equipping 15 hospital projects and one health center in the State of Florida, a construction program of approximately $14,000,000; and

Whereas one hospital project has been completed and nine hospital projects totaling expenditures of over $11,000,000 are now under construction in the State of Florida; and

Whereas S. 614, recently introduced to the Eighty-first Congress, would amend the Hospital Survey and Construction Act of the Seventy-ninth Congress by:

(1) Increasing the contractual obligation authority of the Surgeon General for hospital construction grants from the presently approved $75,000,000 annually to $150,000,000 annually.

(2) Extending the duration of the act 4 years,

(3) Making the grants in each State equivalent to the State's allotment percentage (the allotment percentage of Florida being 57.49) for all projects approved on or after January 1, 1949, in lieu of the presently required national allotment of one-third of the project cost,

(4) Requiring each State to provide annually for State administrative purposes not less than $15,000 or 2 percent, whichever is higher, of the construction funds involved annually in the program,

(5) Providing grants-in-aid to make possible research, experiments, and demonstrations to determine the possibility of coordinating the services of hospitals; and

Whereas with the knowledge and approval of our entire congressional delegation our two Florida Senators have jointly proposed amendments to S. 614 which in effect would:

(1) Make the increased grants proposed by S. 614 for projects approved after January 1, 1949, applicable to projects approved before January 1 in order that all communities constructing hospitals under this program might share equally in the benefits of the program,

(2) Authorize the appropriation of sufficient funds to pay the difference between the presently approved grants of 33⅓ percent and the increased grants based on each State's allotment percentage for all projects approved before January 1, 1949,

(3) Reduce the required State appropriation for administrative purposes from 2 percent to 1 percent of construction costs involved annually in the program; and

Whereas S. 614, with amendments proposed by our two Florida Senators, has been approved by the board of trustees of the Florida Hospital Association, the board of governors of the Florida Medical Association and the hospital division of the Florida State Improvement Commission: Now, therefore, be it

Resolved by the House of Representatives of the State of Florida, the Senate concurring: That the Congress of the United States be, and it is hereby, petitioned and memorialized to enact into law the provisions of S. 614, with the amendments proposed by our two Florida Senators; and be it further

Resolved, That our Senators and Representatives in Congress be commended for their efforts in the interest of our Florida hospital construction program; and be it further

Resolved, That copies of this resolution be forwarded as soon as adopted to each of our United States Senators and to each Member of the National House of

Representatives from the State of Florida in order that each might know that the members of this legislature are cognizant of the good work of our congressional delegation in the interest of Florida hospitals and that our congressional delegation may be reassured in their further efforts by the knowledge that the membership of this legislature considers the adoption of the provisions of S. 614, with amendments proposed by our United States Senators, necessary to the continued fair and harmonious development of our Florida hospital construction program.

RESOLUTION OF THE BOARD OF TRUSTEES OF THE FLORIDA HOSPITAL ASSOCIATION

Whereas S. 614, which proposes to amend the Federal Hospital Survey and Construction Act of the Seventy-ninth Congress, is now being considered by the present Congress; and

Whereas our two Florida Senators have jointly proposed amendments to S. 614, which in effect would make the provisions of this bill applicable to all hospital construction projects for which grants have been approved under the provisions of the present act; and

Whereas the members of this board have carefully studied S. 614, the amendments proposed by our Florida Senators, and data concerning the Florida hospital construction projects which have been approved to date for Federal grants; and

Whereas through these studies this board has concluded that the provisions of S. 614 are in the interest of our Florida hospital construction program and that the retroactive provisions of the amendments proposed by our Florida Senators are not only in the interest of our Florida hospital construction program but are necessary to prevent an injustice to those Florida communities for which grants were approved before January 1, 1949, as evidenced by the following examples:

(1) *Suwannee County Hospital, Live Oak, Fla.*—According to the nationally accepted formula (2½ beds per thousand population served) for minimum hospital needs, a rural area such as is served by the Suwannee County Hospital should have a 70-bed hospital. After several years of careful planning and by straining their financial resources, the people of Suwannee County were able to raise only two-thirds of the cost of building a 36-bed hospital which provides this area with approximately 1.3 beds per thousand population or approximately one-half of the admitted hospital needs of the area. Furthermore, in order to supply two-thirds of the cost of constructing this small hospital it was necessary to delete from the original plans provisions for labor rooms, minor surgery, a nurses' residence and other needed facilities. At present, the Suwannee County Hospital is finding it necessary to rent at a cost of $125 per month a residence to house their nursing and technical staff.

Had the grant for this project been for that proportion of construction costs now proposed by S. 614, the people of Suwannee County would have been able to construct a hospital of a more adequate size and design. If S. 614 is enacted and its provisions are made retroactive, additional funds will be available to construct the much needed facilities which were deleted from the original plans.

(2) *South Florida Crippled Children's Hospital, Coral Gables.*—For the past 8 years the South Florida Children's Hospital Corp. has been raising funds for the construction of a much needed orthopedic hospital for the children of southeast Florida. When detailed estimates were received late last year for the construction of this hospital, it was evident that the funds of the hospital, plus the matching funds provided under the present act, were insufficient to meet the cost of building and equipping the hospital as planned. As a result, it was necessary to eliminate an entire 22-bed nursing unit intended for the treatment of poliomyelitis. Omission of this nursing unit reduced the capacity from 96 to 74 beds. Should the provisions of S. 614 be made retroactive, the owners propose to complete the hospital as originally planned including the nursing unit for treatment of poliomyelitis.

(3) *Southeast Florida Sanatorium, Lantana, Fla.*—The 1947 Legislature of Florida appropriated $2,500,000 to be used by the State tuberculosis board in matching Federal funds for the construction of critically needed tuberculosis sanatoria. When bids were received for a 400-bed sanatorium now under construction at Lantana, it became evident that the State tuberculosis board would have only sufficient funds to meet two-thirds of the cost of building and equipping this one sanatorium. This sanatorium, when completed, together with the existing sanatorium at Orlando, will provide less than one-half of the beds needed to care for tubercular patients in Florida.

Should the provisions of S. 614 be made retroactive, thereby requiring the State tuberculosis board to supply only 42½ percent of the construction costs of this hospital instead of the 66⅔ percent as required by the present act, the board would then have a sufficient balance of unobligated funds in its current State appropriation to match Federal funds on the basis of the new grant percentage proposed by S. 614 to construct a new 220-bed sanatorium which is the next project on the established construction program of the State tuberculosis board.

(4) *American Legion Hospital for Crippled Children, St. Petersburg.*—For over 10 years the American Legion Hospital for Crippled Children, a nonprofit corporation, has been accumulating funds for the purpose of constructing a modern fireproof hospital to replace the present two-story, wood frame, converted residence which they have been operating as a crippled children's hospital for the past 20 years. Because of the nature of the patients served by this hospital, this two-story frame structure has been considered and declared a most serious fire hazard.

When bids were received for the construction of this new hospital, the corporation found that they did not have sufficient funds to defray two-thirds of the cost of constructing and equipping the hospital as planned. As a result, it has been necessary by three series of addenda to the specifications to eliminate facilities both necessary and desirable for the effective operation of a children's hospital to the extent of approximately $70,000 in order that a construction contract might be let. Actual construction has not yet started. If the provisions of S. 614 are made retroactive the facilities which have been deleted from the construction contract could be reinstated and the hospital completed as originally planned.

(5) *Florida A. and M. College Hospital and School for Nurses.*—The construction of this project is most important to all Florida hospitals in order that we might have a continuous supply of well-trained Negro nurses for the care of Negro patients. When bids were received for the construction of this hospital and nursing school it was found that sufficient funds were not available to defray two-thirds of the cost of the project. As a result, Dr. William Gray, president of A. and M. College for Negroes, representing the faculty and student body, asked the State board of control to approve the issuance of revenue certificates to be retired by an infirmary fee which Dr. Gray proposed be levied against all students at A. and M. College for the next 20 years. This infirmary fee, when added to other existing fees, will be a real burden on the students of the A. and M. College. The project was finally approved and placed under construction only a few days before January 1, 1949. According to the provisions of S. 614 had this project been approved and placed under construction after January 1, 1949, the issuance of these revenue certificates and the assessment of student fees would not have been necessary. Should the provisions of S. 614 be made retroactive, it will not be necessary to execute the revenue certificates as proposed; and

Whereas the problems of the remaining 10 Florida projects which were approved before January 1 are known to be similar to the five examples aforestated: Now, therefore, be it

Resolved, That the board of trustees of the Florida Hospital Association, meeting in Jacksonville this 25th day of March 1949, hereby tenders its full approval and support of S. 614, as amended by our Florida Senators; and be it further

Resolved, That a copy of this resolution be sent to each member of our Florida congressional delegation in order that each might know that we are cognizant of their good work in the interest of Florida hospitals and may be reassured in their further efforts by the knowledge that this board considers these retroactive amendments necessary to the continued fair and harmonious development of our Florida hospital construction program.

Resolution of the Assembly of the Southeastern Hospital Conference

Whereas the Seventy-ninth Congress, through the provisions of the Federal Hospital Survey and Construction Act, established a national program to assist the several States to inventory their existing hospitals, define their hospital needs, and formulate State plans for the construction of needed new hospitals; and

Whereas through this program grants have been approved for one-third of the cost of planning, constructing, and equipping 165 hospital and health-center projects in the 6 States—Alabama, Florida, Georgia, Louisiana, Mississippi, and Tennessee—comprising the Southeastern Hospital Conference; and

Whereas these 165 approved projects represent a construction program of approximately $86,666,000; and

Whereas S. 614, recently introduced to the Eighty-first Congress, would amend the Hospital Survey and Construction Act of the Seventy-ninth Congress by:

(1) Increasing the contractual obligation authority of the Surgeon General for hospital-construction grants from the presently approved $75,000,000 annually to $150,000,000 annually,

(2) Extending the duration of the act 4 years,

(3) Making the grants in each State equivalent to the State's allotment percentage for all projects approved on or after January 1, 1949, in lieu of the presently required national allotment of one-third of the project cost,

(4) Requiring each State to provide annually for State administrative purposes not less than $15,000, or 2 percent, whichever is higher, of the construction funds involved annually in the program,

(5) Providing grants-in-aid to make possible research, experiments, and demonstrations to determine the possibility of coordinating the services of hospitals, and

Whereas because of the chronically depressed economy of the Southeastern States through the years, and because through both the depression and war years it has been most difficult to finance and construct hospitals, the need for additional hospital facilities in these States has become most acute; and

Whereas because of present high construction costs and our declining agricultural market it has become difficult for southern communities to finance two-thirds of the cost of constructing needed hospital facilities: Now, therefore, be it

Resolved, That the assembly of the Southeastern Hospital Conference meeting in Biloxi, Miss., April 27, 28, and 29, 1949, hereby expresses approval and tenders support of S. 614 of the Eighty-first Congress with the recommendation that the three following amendments to S. 614 be accepted by the Congress for the reasons given following the statement of each recommended amendment:

1. Page 5, line 18, strike out "January 1, 1949," and insert in lieu thereof "August 13, 1946."

Reasons for recommending this amendment: According to S. 614, all grants approved after January 1, 1949, would be for that portion of the project equivalent to the State's allotment percentage. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. To date construction grants have been approved for 165 projects in the 6 States comprising this conference, several of which have been completed and others of which have been recently placed under construction. The majority of these projects were approved before January 1, 1949. According to S. 614, grants for the completed projects and those projects which were placed under construction before January 1 would remain pegged at one-third of construction cost; and, depending upon the interpretation which may be given by the general counsel of the Public Health Service, the projects which have been approved but which are not yet under construction might also be placed in the same category. This would mean that southern communities which have exercised the greatest courage and initiative in floating bond issues, preparing plans, and which have placed their hospitals under construction at an early date would be penalized; and those communities which have exercised less courage and initiative and whose hospitals will not go under construction until some future date would receive grants in excess of one-third of construction costs.

It is felt most important that the proposed increase in grant percentage be made retroactive to the beginning of the program in order that all communities building hospitals might share equally in the benefits of the program. If this were an old program and if many hospitals had been completed under the provisions of the present act, it would be unreasonable to request that the new allotment percentage be made retroactive; however, since the program is so new with so few projects actually placed under construction throughout the Nation and with only a few projects completed in the entire United States it appears only reasonable that the increased grant percentage be made applicable to all approved projects. This contention is substantiated by the fact that the majority of projects approved before January 1, 1949, were approved during the last half of 1948. Many were approved during the month of December 1948.

2. Page 2, after line 12, insert the following new subsection:

"(c) There is hereby authorized to be appropriated such sum as may be necessary to pay the additional Federal aid provided in section 3 (a) of this act with respect to projects approved on and after August 13, 1946, and prior to January 1, 1949, in accordance with section 7 of this act, it being the intent of this act that Federal aid for projects approved on and after January 1, 1949, shall be provided from authorizations contained in subsections (a) and (b)."

Reasons for recommending this amendment: If amendment number 1, as recommended above, is enacted it would be necessary to provide funds to pay the difference between the presently approved grants of one-third and the new allotment percentage proposed by S. 614; otherwise there would not be sufficient funds in the current allotment of many States to adjust grants at the rate of the increased factor.

To make the new allotment percentage retroactive to the beginning of the program without a specific appropriation to supply necessary funds from which to pay the increased grants would be disastrous to the program in the Southeast as well as to programs of all States which have any sizable portion of their proposed projects under construction. The Southeastern States have a larger proportion of their proposed projects under construction than does any other area of the Nation.

3. Page 3, line 13, strike out the figure "2" and insert in lieu thereof the figure "1."

Reasons for recommending this amendment: The State agencies administering this program in the Southeast are of the opinion that 2 percent of the total funds proposed to be expended during a budget year would equal approximately double the amount which is actually needed for administrative purposes. It is believed that to require a State to supply administrative funds in excess of actual need would not only constitute a waste of public moneys but would tend to decrease efficiency of administration and encourage the development of "red tape"; and be it further

Resolved, That a copy of this resolution be sent to each member of the congressional delegations of the six States comprising this conference, together with a letter of transmittal expressing appreciation for the support which our southern congressional delegations have given to progressive hospital legislation in the past and requesting their concerted support of S. 614 with the amendments herein recommended.

Resolution of the Assembly of the Southeastern Hospital Conference

Whereas the Seventy-ninth Congress, through the provisions of the Federal Hospital Survey and Construction Act established a national program to assist the several States to inventory their existing hospitals, define their hospital needs, and formulate State plans for the construction of needed new hospitals; and

Whereas through this program grants have been approved for one-third of the cost of planning, constructing, and equipping 165 hospital and health center projects in the six States—Alabama, Florida, Georgia, Louisiana, Mississippi, and Tennessee—comprising the Southeastern Hospital Conference; and

Whereas these 165 approved projects represent a construction program of approximately $86,666,000; and

Whereas S. 614, recently introduced to the Eighty-first Congress, would amend the Hospital Survey and Construction Act of the Seventy-ninth Congress by:

(1) Increasing the contractual obligation authority of the Surgeon General for hospital construction grants from the presently approved $75,000,000 annually to $150,000,000 annually.

(2) Extending the duration of the act 4 years.

(3) Making the grants in each State equivalent to the State's allotment percentage for all projects approved on or after January 1, 1949, in lieu of the presently required national allotment of one-third of the project cost.

(4) Requiring each State to provide annually for State administrative purposes not less than $15,000 or 2 percent, whichever is higher, of the construction funds involved annually in the program.

(5) Providing grants in aid to make possible research, experiments, and demonstrations to determine the possibility of coordinating the services of hospitals; and

Whereas because of the chronically depressed economy of the Southeastern States through the years and because through both the depression and war years it has been most difficult to finance and construct hospitals, the need for additional hospital facilities in these States has become most acute; and

Whereas because of present high construction costs and our declining agricultural market it has become difficult for southern communities to finance two-thirds of the cost of constructing needed hospital facilities: Now, therefore, be it

Resolved, That the assembly of the Southeastern Hospital Conference meeting in Biloxi, Miss., April 27, 28, and 29, 1949, hereby expresses approval and tenders support of S. 614 of the Eighty-first Congress with the recommendation that the three following amendments to S. 614 be accepted by the Congress for the reasons given following the statement of each recommended amendment:

1. Page 5, line 18, strike out "January 1, 1949" and insert in lieu thereof "August 13, 1946."

Reasons for recommending this amendment: According to S. 614, all grants approved after January 1, 1949, would be for that portion of the project equivalent to the State's allotment percentage. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. To date construction grants have been approved for 165 projects in the six States comprising this conference, several of which have been completed and others of which have been recently placed under construction. The majority of these projects were approved before January 1, 1949. According to S. 614 grants for the completed projects and those projects which were placed under construction before January 1 would remain pegged at one-third of construction cost; and, depending upon the interpretation which may be given by the General Counsel of the Public Health Service, the projects which have been approved but which are not yet under construction might also be placed in the same category. This would mean that southern communities which have exercised the greatest courage and initiative in floating bond issues, preparing plans and which have placed their hospitals under construction at an early date would be penalized; and those communities which have exercised less courage and initiative and whose hospitals will not go under construction until some future date would receive grants in excess of one-third of construction costs.

It is felt most important that the proposed increase in grant percentage be made retroactive to the beginning of the program in order that all communities building hospitals might share equally in the benefits of the program. If this were an old program and if many hospitals had been completed under the provisions of the present act, it would be unreasonable to request that the new allotment percentage be made retroactive; however, since the program is so new with so few projects actually placed under construction throughout the Nation and with only a few projects completed in the entire United States it appears only reasonable that the increased grant percentage be made applicable to all approved projects. This contention is substantiated by the fact that the majority of projects approved before January 1, 1949, were approved during the last half of 1948. Many were approved during the month of December 1948.

2. Page 2, after line 12, insert the following new subsection:

"(c) There is hereby authorized to be appropriated such sum as may be necessary to pay the additional Federal aid provided in section 3 (a) of this act with respect to projects approved on and after August 13, 1946, and prior to January 1, 1949, in accordance with section 7 of this act, it being the intent of this act that Federal aid for projects approved on and after January 1, 1949, shall be provided from authorizations contained in subsections (a) and (b)."

Reasons for recommending this amendment: If amendment number 1, as recommended above, is enacted it would be necessary to provide funds to pay the difference between the presently approved grants of one-third and the new allotment percentage proposed by S. 614; otherwise, there would not be sufficient funds in the current allotment of many States to adjust grants at the rate of the increased factor.

To make the new allotment percentage retroactive to the beginning of the program without a specific appropriation to supply necessary funds from which to pay the increased grants would be disastrous to the program in the Southeast as well as to programs of all States which have any sizable portion of their proposed projects under construction. The Southeastern States have a larger proportion of their proposed projects under construction than does any other area of the Nation.

3. Page 3 line 13, strike out the figure "2" and insert in lieu thereof the figure "1."

Reasons for recommending this amendment: The State agencies administering this program in the Southeast are of the opinion that 2 percent of the total funds proposed to be expended during a budget year would equal approximately double the amount which is actually needed for administrative purposes. It is believed that to require a State to supply administrative funds in excess of actual need would not only constitute a waste of public moneys but would tend to decrease efficiency of administration and encourage the development of "red tape"; and be it further

Resolved, That a copy of this resolution be sent to each member of the congressional delegations of the six States comprising this conference, together with a letter of transmittal expressing appreciation for the support which our southern congressional delegations have given to progressive hospital legislation in the past and requesting their concerted support of S. 614 with the amendments herein recommended.

Resolution of the Board of Governors of the Florida Medical Association

Whereas the Seventy-ninth Congress through the provisions of the Federal "Hospital Survey and Construction Act" established a national program to assist the several States to inventory their existing hospitals, define their hospital needs, and formulate State plan for the construction of needed new hospitals; and

Whereas through this program grants have been approved for one-third of the cost of planning, constructing and equipping 15 hospital projects and 1 health center in the State of Florida, a construction program of approximately $14,00,000; and

Whereas one hospital project has been completed and eight hospital projects totaling expenditures of approximately $10,000,000 are now under construction in the State of Florida; and

Whereas S. 614, recently introduced to the Eighty-first Congress, would amend the Hospital Survey and Construction Act of the Seventy-ninth Congress by:

(1) Increasing the contractual obligation authority of the Surgeon General for hospital construction grants from the presently approved $75,000,000 annually to $150,000,000 annually.

(2) Extending the duration of the act 3 years.

(3) Making the grants in each State equivalent to the State's allotment percentage for all projects approved on or after January 1, 1949, in lieu of the presently required national allotment of one-third of the project cost,

(4) Requiring each State to provide annually for State administrative purposes not less than $15,000 or 2 percent, whichever is higher, of the construction funds involved annually in the program,

(5) Providing grants-in-aid to make possible research, experiments and demonstrations to determine the possibility of coordinating the services of hospitals, and

Whereas because of the rapid population growth of Florida through both the depression years and the war years, during which periods it was difficult both to finance and to construct hospitals, the need for additional hospital facilities in Florida has become most acute; and

Whereas because of present high construction costs and our declining agricultural market, it has become difficult for Florida communities to finance two-thirds of the cost of constructing needed hospital facilities: now, therefore, be it

Resolved, That the board of governors of the Florida Medical Association meeting in Jacksonville on February 27, 1949, hereby expresses approval and tenders support of S. 614 of the Eighty-first Congress with the recommendation that the three following amendments to S. 614 be accepted by the Congress for the reasons given following the statement of each recommended amendment:

1. Page 5, line 18, strike out "January 1, 1949" and insert in lieu thereof "August 13, 1946."

Reasons for recommending this amendment: According to S. 614 all grants approved after January 1, 1949, would be for that portion of the project equivalent to the State's allotment percentage, or in the case of Florida 57.49 percent. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. To date construction grants have been approved for 16

Florida projects, 1 of which has been completed and 8 of which are now under construction. Fifteen of these projects were approved before January 1, 1949. Grants for the one completed project and the eight projects under construction, according to S. 614, would remain pegged at one-third of construction cost; and, depending upon the interpretation which may be given by the general counsel of the Public Health Service, the other six Florida projects which have been approved but which are not yet under construction might also be placed in the same category. This would mean that communities which have exercised the greatest courage and initiative in floating bond issues, preparing plans and which have placed their hospitals under construction at an early date would be penalized; and that those communities which have exercised less courage and initiative and whose hospitals will not go under construction until some future date would receive grants greatly in excess of one-third of construction costs.

It is felt most important that the proposed increase in grant percentage be made retroactive to the beginning of the program in order that all communities building hospitals might share equally in the benefits of the program. Otherwise, communities now planning construction might indefinitely postpone construction in expectation of a third change in the act which would increase the grants even more than now proposed under S. 614.

2. Page 2, after line 12, insert the following new subsection:

"(c) There is hereby authorized to be appropriated such sum as may be necessary to pay the additional Federal aid provided in section 3 (a) of this act with respect to projects approved on and after August 13, 1946, and prior to January 1, 1949, in accordance with section 7 of this act, it being the intent of this act that Federal aid for projects approved on and after January 1, 1949 shall be provided from authorizations contained in subsections (a) and (b)."

Reasons for recommending this amendment: If amendment No. 1, as recommended above, is enacted it would be necessary to provide funds in an amount necessary to pay the difference between the presently approved grants of one-third and the new allotment percentage proposed by S. 614. Otherwise, there would not be sufficient funds in the current allotment of many States to pay grants at the rate of the increased factor. For instance, according to a statement prepared by the Florida State Improvement Commission, it would require in excess of $1,500,000 to increase the grants now approved for Florida projects from one-third of the cost of construction to the proposed new allotment of 57.49 percent.

To make the new allotment percentage retroactive to the beginning of the program without a specific appropriation to supply necessary funds from which to pay the increased grants would be disastrous to our Florida program as well as to programs of all States which have any sizable portion of their proposed program under construction. This is particularly true for Florida, for the State Improvement Commission has a larger proportion of their proposed program under construction than does any other State in the Union.

3. Page 3, line 13, strike out the figure "2" and insert in lieu thereof the figure "1".

Reasons for recommending this amendment: We are informed by the Florida State Improvement Commission that 2 percent of the total funds proposed to be expended during a budget year would equal approximately double the funds which are actually needed for administrative purposes. It is believed that to require a State to supply administrative funds in excess of actual need would not only constitute a waste of public funds but would tend to decrease efficiency of the administration and encourage the development of "red tape"; and be it further

Resolved, That a copy of this resolution be sent to each member of our Florida congressional delegation, together with a letter of transmittal expressing appreciation for the enthusiastic support which we understand our delegation has given to S. 614 and the amendments herein recommended, and encouraging their continued support.

Amendment to H. R. 3737 proposed by Mr. ———.

Page 5, strike out "(a)" in line 21.

Amendment to H. R. 3737 proposed by Mr. ———.

Page 3, strike out "623" in line 1 and insert in lieu thereof "625."

Mr. Priest. Mr. Rich.

STATEMENT OF HON. ROBERT F. RICH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. Rich. Mr. Chairman and members of the committee, I thank you for the privilege of coming here for a few moments of your time.

In reference to the Williamsport Hospital, Williamsport, Pa., I have a letter that I received from Mr. John H. McCormick, chairman, Williamsport Hospital Board of Trustees, relative to the extension of the privileges under the bills that have been proposed for hospitalization that are now under construction, which would cost a great deal more money than they anticipated, and it is hoped that the bill H. R. 3737, introduced by our colleague, Mr. Bennett of Florida, including those hospitals that have already been granted privileges of donations, will be favorably considered for future aid and assistance much needed, and needed now.

The Williamsport Hospital had put on a campaign for more than a million dollars several years ago, and then with the grant they received they are unable to complete the work, and it was necessary for them to go out and get more money. They borrowed money. At the present time they are putting on a new campaign to try to get more money to complete the job, but because of the fact that in that community they have had more hospital campaigns in the last couple of years they are unable to raise the required sum to complete the work already started.

I wrote a letter the other day to the chairman of this subcommittee, Mr. Percy Priest, requesting aid for the Williamsport hospital, and I am going to quote this from the letter, which I received from Mr. John H. McCormick, who is the chairman of the hospital board. He said, and I quote:

> In the case of the Williamsport hospital, we were granted a hospital-construction project last year and embraced in this construction-project program was the borrowing of over $100,000 by the Williamsport Hospital to cover that portion of the cost for which we did not have funds on hand.
>
> At the present time, the Williamsport Hospital is engaged in a building-fund campaign and we do not believe that this campaign will prove to be successful. Part of the funds, which we had hoped to raise in the campaign were to be used to liquidate loans which we will have to make to pay for the hospital now under construction, and the funds will be not nearly sufficient to pay for the additional construction needed over and above our present project.
>
> Therefore, it is our feeling that if any additional funds are made available for hospital construction, those hospitals which were approved for projects prior to January 1, 1949, should be included in the group to participate in additional funds.

It seems to me that they should be given consideration in your deliberations here for the proper construction of those hospitals that have already been started, and the reason for it is the high cost of construction.

I thank you for the privilege of being here, and I am sure you will give proper consideration to those hospitals that have already been granted the privilege of going ahead, but find now they are unable to proceed unless they can get additional funds.

Mr. Priest. You can be assured, Mr. Rich, that we will give it proper consideration.

Are there any questions?

Mr. Wilson. Yes, Mr. Chairman.

Mr. RICH. I have suggested H. R. 3737, which was introduced by Mr. Bennett, of Florida, as one that possibly would carry out the proper construction program.

Mr. WILSON. Mr. Chairman, I would like to ask Mr. Rich if, in his opinion and experience, as a Representative in Congress observing matters that touch upon the economy of the country, whether or not he believes it to be a sound financial policy for the Government to go ahead and make appropriations for the further construction and enlargement of hospitals.

Mr. RICH. Well, it seems to me there are many things we are doing that are not so important as taking care of the sick.

When any of our soldiers are injured, there is nothing too good for those that have been injured and those who are sick, and there is nothing that we, as Members of Congress, will not do to take care of them. The same thing applies to our citizens. When a man is sick the best thing we can do for him is to give him hospitalization, and I have never yet felt that we should, in any way, prohibit our Government from aiding and assisting in every way possible, we can, in taking care of the needy and the sick. I think they are the two most important things we have to do. Especially if he cannot afford it.

When a man is physically able to work he can get out and work and dig for a living, the same as you and I; but when a man is physically incapacitated somebody has got to take care of him, and I am one who wants to try, in my humble way, to do what I can to take care of those people.

Mr. WILSON. Of course, you realize that there are bills pending here before the committee to increase the percentage of outlay from a third to 50 percent and even to two-thirds.

Mr. RICH. I think that there is probably need for that over the country, but we have got great opportunities; we have many opportunities that we can keep funds in our Treasury from going out that are not so important as funds of that kind.

I firmly believe in taking care of, and building hospitals, and looking after our sick. I do not want anyone to think that because of my economy-mindedness that I want to in any wise stint those people.

Mr. WILSON. You are firmly convinced of that in your own opinion?

Mr. RICH. That is right; I certainly am.

Mr. WILSON. And your opinion is and would go as far as not to stint or hold back on the funds on this program?

Mr. RICH. I should do this: I think it wise, and I do not believe in expending money extravagantly. I think in building hospitals they should build hospitals with the idea of being able to give services to civilians and veterans, but we do not have to have a lot of the expensive construction that someone might want to go into hospitals. I think we ought to be careful there and know that every dollar is going to count.

Mr. WILSON. I agree with you there that every dollar ought to count, and I am trying to sound you out definitely as to the soundness of the policy of putting Federal-public funds into hospital construction; and I take it from what you have said, you are in accord with that program.

Mr. RICH. I am on the board of one of the hospitals, the Lock Haven Hospital, and the thought and idea there is that we want the people that can afford to pay into the hospital funds each year to do so. We put on big campaigns. We raise a lot of money to take care of those hospitals. We try to look after that hospital with the idea that we are going to give it a good business administration, and I think we do.

We are constructing the Lock Haven Hospital now, but we are careful of every dollar that we spend and the architects' plans are not to use a lot of funds unnecessarily.

Mr. **Wilson.** Mr. Rich, at the risk of going beyond the time allotted me by the committee, I want to ask you this question. I want to put to you a question that I have asked a number of other witnesses along this line in the course of these hearings over several weeks.

Why is it, in your opinion, and you are a member of one of the boards of one of the hospitals—why is it true that in the course of time, in recent years at least, that the contributions from private individuals and private organizations have steadily decreased instead of increasing?

Mr. **Rich.** Well, in our hospital, I do not believe they have decreased so much; but the costs have increased so much and to such an extent that we cannot, with the money that we have been securing, we cannot do today what we did a few years ago. Also taxes take so much of our earnings, people cannot give as much as the hospitals need.

Mr. **Wilson.** You spoke of the fact a while ago that there had been so many calls in that particular community that it was hard to get any more.

Mr. **Rich.** That is right. Well, we are finding this out: For instance, in Lock Haven, they have a Piper Cub aircraft factory there that employs three or four thousand people. Today there is a couple of thousand of those people who are not able to be kept on the pay roll because of the lack of demand for the smaller airplanes. Therefore, we do not have the opportunity to secure as many contributions, although others have given.

So I do not think that it is because we have fallen down in our contributions, as much as it is in the high cost of living and it is harder to get money.

Mr. **Wilson.** Whatever the reason is, you think there still remains a sound need for Federal funds for hospital construction?

Mr. **Rich.** That is right. I do.

Mr. **Wilson.** Thank you.

Mr. **Rich.** I think we have the demand for Government aid, and I think that we ought to do something to build community hospitals and we will not have to build so many Government hospitals. It will be cheaper for us in the long run.

Mr. **Priest.** Are there any further questions?

Thank you so much, Mr. Rich.

Mr. **Rich.** Thank you.

STATEMENT OF HON. E. L. BARTLETT, DELEGATE IN CONGRESS FROM THE TERRITORY OF ALASKA

Mr. **Priest.** We will next hear our colleague, the Delegate from Alaska, Mr. Bartlett, who introduced H. R. 323, which is also before the committee. We will be happy to hear you at this time, Mr. Bartlett.

Mr. Bartlett. Thank you, Mr. Chairman, and members of the committee. I shall not attempt to detain the committee long in connection with H. R. 323, because the committee has gone thoroughly into this subject in the past. In the last Congress, I introduced H. R. 4816, the purpose of which was to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $250,000 to each State for the construction of hospitals.

This committee held hearings on that bill and reported it out unanimously, I believe, and it was passed by the House.

Thereafter, and elsewhere, the amount was reduced and I think without any committee hearings, to $100,000 for each State and Territory, and it was late in the session, so the Senate version became law, Public Law 830 of the Eightieth Congress. On January 3 of this year, I introduced H. R. 323, intended to provide, again, the minimum of $250,000 for each State for hospital construction, and term "State" there is used to include the Territories.

I should like to offer for the record, if I may, Mr. Chairman, a resolution adopted on this subject by the Alaska Territorial Board of Health and a Memorial by the Alaska Territorial Legislature.

(The documents referred to are as follows:)

Resolution Adopted by the Board of Health of the Territory of Alaska, October 28, 1948

Whereas the board of health is cognizant of the great shortage of hospital facilities in the Territory, and

Whereas many communities in the Territory are too sparsely settled to raise sufficient funds to construct hospitals without outside financial assistance, and

Whereas the Honorable E. L. Bartlett, Delegate to Congress from Alaska, has introduced an amendment to the Federal Hospital Survey and Construction Act to provide $250,000 in place of $100,000 per year, now authorized to construct hospitals in the States and Territories: Therefore be it

Resolved, That the Board of Health of the Territory of Alaska go on record supporting Delegate Bartlett's efforts in behalf of this amendment.

[In the Senate. By Senator McCutcheon. Senate Joint Memorial No. 15. In the Legislature of the Territory of Alaska, nineteenth session]

To the Congress of the United States, the United States Public Health Service, and the Honorable E. L. Bartlett, Delegate to Congress from Alaska:

Your memorialist, the Legislature of the Territory of Alaska in nineteenth session assembled, respectfully submits:

Whereas the people of Alaska are desirous of bringing the Territory to a high state of development and the health of our people is of prime importance in the development of the Territory; and,

Whereas the Honorable E. L. Bartlett, Delegate to Congress from Alaska, has introduced an amendment to the Federal Hospital Survey and Construction Act to provide $250,000 in place of $100,000 per year now authorized to construct hospitals in the Territory in order to provide the best possible care for Alaskan citizens; and,

Whereas Alaskan communities must depend on Federal subsidy to assist them in constructing community facilities;

Now, therefore, your memorialist, the Legislature of the Territory of Alaska, respectfully urges that the Congress favorably consider the amendment to the Federal Hospital Survey and Construction Act introduced by Hon. E. L. Bartlett, Delegate to Congress from Alaska.

And your memorialist will ever pray.

Mr. Bartlett. Now, I could go on for some time and give you my ideas about the desirability of this legislation, but the whole matter was so well covered in the report made by Congressman Hall from this committee on May 11 of last year, being Report No. 1929, that I do not think it will be necessary for me to elaborate. That report spells out in some detail why this committee believed legislation of this type to be desirable, and so I shall not proceed any further, Mr. Chairman.

Mr. PRIEST. Without objection, the resolutions and memorials will be included in the record.

I believe you are quite right, Mr. Bartlett, that the committee, having considered this matter last year, and reported favorably on your bill at that time, is fully aware of the need for this legislation, affecting Alaska in particular.

Mr. BARTLETT. Yes.

Mr. PRIEST. May I ask just one question: Would this matter which your bill specifically deals will be covered by any of the other bills before the committee, so far as you know?

Mr. BARTLETT. I cannot answer that. I wish I could. I thought this morning when I came in I probably should have checked that, but did not. I should like to say——

Mr. PRIEST. It is my opinion that it does not.

Mr. BARTLETT. I am not sure. The Federal Security Agency and the Department of the Interior advocated such legislation and in the report to which I previously referred, the total additional amount authorized to raise the allotments of all of the States that was spelled out, would have been $758,000; the additional amount required over and above the amount now authorized would be something, I believe, in the neighborhood of $454,000.

Mr. PRIEST. We thank you, Mr. Bartlett.

Mr. BARTLETT. Thank you very much.

STATEMENT OF HON. NORRIS POULSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. PRIEST. Next we will hear Mr. Norris Poulson of California.

Mr. POULSON. Mr. Chairman and members of the committee, I am appreciative of the fact that I have an opportunity to say a few words concerning the amendment to the bill that I have introduced. It touches just one phase of this problem. But, before I bring this up, I would like to make just this general statement which I think expresses the views of the majority of those in the hospital field in California. I had considerable experience there, having had close contact with the hospitals and helping them reorganize, in setting them up as nonprofit ventures, through my profession as a certified public accountant, and I know what most of the problems are out there.

I think that this is definitely one of the sound approaches to our health and medical proplems that we have throughout the country. I think that we definitely have a responsibility in this field—in fact, it is a responsibility not only of the Government to build hospitals but in this connection we have reached a similar stage as we have in the development of our public power. There was a time when the private companies could develop our power. Now it has gotten to be such a big project that it is up to the Government to build them.

People do not realize that in building a hospital there is the necessity of having everything in it.

A hospital, frankly, is not worth much unless it absolutely has all of the modern facilities, because that in itself increases the efficiency for every dollar put in it after you build the building, in the way of equipment, and of modern devices that they have, and which are necessary in that connection and adds to the efficiency and, of course, the production from the hospital. Naturally, that costs a lot of money.

And I think—of course, I am not speaking for the hospitals or the medical profession when I say that, in my personal opinion in the same field, we need to build hospitals and we need to help in the education of doctors. We have got a shortage of doctors, and we need that rather than trying to regulate what doctors we have. That is one of the biggest problems we have.

But, coming to H. R. 4763, you are entering this field in the matter of assistance in the construction of hospitals. The point that we want to emphasize is the fact that we believe—and it is written out in this bill, H. R. 4763—that this money should be allocated on the basis of the population and definitely taking into consideration the increase in population from 1940 to 1947. We have a formula here for working out that matter of an increase.

Now, to give you an idea of what we are up against. You take California. We have had a million and a half people increase in population from 1940 to 1947. Oregon has had a greater percentage increase; they have had an increase of around 450,000 people. The State of Washington has had an increase of 600,000 people. In fact, all of the 11 Western States have had a large increase in their population, and on the basis of the present allocation of 1940 census you can see that some States are receiving more in proportion and some of them less. For instance, I have a comparison here to give you an idea.

Los Angeles County alone has an increase of over a million in population—and I have a chart here which is quite extensive—so I will not attempt to read it to you; but it gives you an idea. I would like to have permission to put this in the record. It gives you an idea of the increase in amounts that we are receiving.

Take, for instance, on the basis of income taxes, whether we are entitled to it on the basis of Federal income taxes or not; but, based on 1948 tax collections, the State of California paid $2,421,000,000, and we received back $1,956,000.

The State of Mississippi paid in $90,000,000. That gives you an idea of the inequity of the distribution on the present basis.

Mr. Priest. The figures that you gave there as to what California received back—that was for hospital construction?

Mr. Poulson. Yes; that is right.

Now, I do not need to elaborate on the fact that there is a great adjustment in the matter of population at this time necessary, and I think there should be a formula established so that that could be adjusted during the 10-year period on the basis of the estimates made by the United States Census Bureau, and it is nothing but fairness to any State. It so happens that California happens to be on the increase. It could go the other way. But, in fairness, it should be allocated on that basis, and that is the purpose of the bill which I have introduced.

Mr. PRIEST. The formula of allocation?

Mr. POULSON. Yes, sir.

Mr. PRIEST. Are there any questions?

We thank you, Mr. Poulson, for your statement, and I assure you that the committee will give it due consideration.

It was the intention of the Chair to call Dr. Dearing, who is the Acting Surgeon General. The House meets in about 15 minutes, and it will be necessary for the committee to adjourn at 11 o'clock.

We have our former colleague Jerry Voorhis here. He has a speaking engagement, and I am sure Dr. Dearing will be able to be before the committee tomorrow. We are going to call Mr. Voorhis at this time.

(The schedules above referred to are as follows:)

SCHEDULE NO. A.—*Population figures for Los Angeles County and State of California*

Los Angeles County:	
1940 census	2,785,643
Jan. 1, 1949	3,881,323
California:	
1940 census	6,907,387
Jan. 1, 1949	10,264,400

SCHEDULE NO. B.—*Federal income-tax collections, 1948, as compared with allotments under Public Law 725*

National	$31,062,899,000	$75,000,000
California	2,421,814,000	1,956,160
Mississippi	90,924,000	2,401,451
Georgia	342,809,000	2,976,228
Alabama	234,632,000	2,885,880

The following charts are part of the article by Ritz E. Heerman on Comparison of Occupancy Trends and the Relationship to Hospital Economics.

CHART NO. 1.—*Bed utilization considering only adult beds in voluntary general hospitals*

City	Number of beds	Admissions	Utilization rate	City	Number of beds	Admissions	Utilization rate
WESTERN HOSPITALS				HOSPITALS, MIDDLE WEST AND EAST			
Seattle	1,556	58,130	38	St. Louis	3,644	104,591	28
Spokane	865	29,215	34	Twin Cities	3.254	122.179	37
Portland	1,701	57,866	34	Baltimore	3.764	102,325	27
San Francisco	2.749	91,523	33	Hartford	1,332	46,178	34
Los Angeles	2,709	104,083	38	Philadelphia	8,298	202,794	24
				Omaha	1,312	46,131	34

CHART NO. 2.—*Bed utilization considering only adult beds in city and county general hospitals*

City	Number of beds	Admissions	Utilization rate	City	Number of beds	Admissions	Utilization rate
Seattle	500	12,015	24.0	St. Paul	850	7,029	8.0
San Francisco	1,366	18,736	13	Baltimore	2,026	7,480	3.6
Los Angeles	3,394	58,418	17	Hartford	296	4,310	14.0
St. Louis	1,753	30,315	17	Philadelphia	2,500	22,053	8.0
Minneapolis	574	9,259	16	Omaha	304	2,391	7.0

CHART No. 3.—*Utilization of infant beds in maternity departments in voluntary general hospitals*

City	Bassinets	Births	Utilization rate	City	Bassinets	Births	Utilization rate
Seattle	357	13, 180	37	Twin Cities	634	26, 561	42
Spokane	130	5, 645	43	Baltimore	574	22, 654	39
Portland	293	11, 762	40	Hartford	296	8, 548	29
San Francisco	433	17, 289	39	Philadelphia	1, 472	44, 678	30
Los Angeles	491	22, 342	45	Omaha	226	6, 996	31
St. Louis	576	18, 885	32				

CHART No. 4.—*Utilization of infant beds in maternity departments in city and county general hospitals*

City	Bassinets	Births	Utilization rate	City	Bassinets	Births	Utilization rate
Seattle	51	942	18	St. Paul	55	222	4
San Francisco	50	1, 378	27	Baltimore	80	1, 784	22
Los Angeles	230	4, 677	20	Hartford	6	89	15
St. Louis	139	2, 908	20	Philadelphia	60	2, 130	35
Minneapolis	55	591	11				

CHART No. 5.—*Percentage of increase in cost per case from 1939*

Year	Washington	Oregon	Northern California	Southern California	Average
1942	14. 6		4. 1	16. 6	9. 3
1945	32. 6	1. 0	19. 9	50. 7	29. 2
1948	117. 4	72. 4	80. 0	79. 2	99. 5

CHART No. 6.—*Percentage of increase in cost per day from 1939*

Year	Washington	Oregon	Northern California	Southern California	Average
1942	−0. 009		−0. 008	10. 4	1. 2
1945	33. 0	26	24. 1	61. 7	35. 7
1948	145. 5	100	133. 0	157. 6	139. 6

CHART No. 7.—*Cost of living index* (*Source: Bureau of Labor Statistics*)

	1939	1942	1945	1948
United States	99. 4	116. 5	128. 4	171. 4
Percent of increase over 1939		17. 2	29. 2	72. 4

It might also be noted that certain specific items of living costs have had the following increases since 1939: Food, from 95.2 in 1939 to 214.1 in 1948; increase, 125 percent; clothing, from 100.5 in 1939 to 196.9 in 1948; increase, 95.9 percent

CHART No. 8.—*Cost per day*

Year	Washington	Oregon	Northern California	Southern California	Average
1939	7.44		10.60	9.13	8.89
1942	7.37	7.78	10.51	10.08	9.00
1945	9.90	9.40	13.14	14.77	12.07
1948	18.27	15.57	24.70	23.52	21.30

STATEMENT OF JERRY VOORHIS, EXECUTIVE SECRETARY, COOPERATIVE HEALTH FEDERATION OF AMERICA, CHICAGO, ILL.

Mr. VOORHIS. Mr. Chairman, I am very grateful to you and the members of the committee and to Dr. Dearing, and I assume that the committee wants to be out of here in just a little while, so I would like to do three things, if I may.

In the first place, I would like to, in about 2 or 3 minutes, tell you the main things that I want to say and then if you still have patience with me, I would like to read a few excerpts from my statement and then I would like to ask permission to insert my statement.

Mr. PRIEST. The Chair will state on behalf of the committee that, knowing you as all of us do, we always have patience with you, Mr. Voorhis.

Mr. VOORHIS. Well, people have had a good deal, I will say that, Mr. Chairman.

I would like to say before I start that coming back here this morning brings back very poignant memories, and rather strong emotions. For example while listening to the gentleman from California tell how much the population of Los Angeles County has increased. I felt very much at home.

Now, first of all, I think that everybody is agreed that the problem of the Nation's health is a problem of the Nation's concern.

I was most interested in listening to the testimony of some of the gentlemen who were here this morning on that point.

In the second place, I think we need to recognize that if we are ever to solve this problem, regardless of what is done, about our national-health insurance bill, that it is evident that there needs to be increased facilities for the training of doctors and other professional personnel; that there needs to be additional research and that there needs to be more facilities in all parts of the country.

I am here speaking for the Cooperative Health Federation of America, which is an organization of group health plans and includes in its direct membership, its regular membership, most of the more successful of the group health and cooperative health plans. It has 21 regular members and 30 associate members, and those associate members include a good many organizations of a civic nature, labor unions, farm organizations, and farm cooperatives.

I want to say that our organization is concerned primarily with the solution of the whole health problem of the Nation. Our special job is to see that the cooperative method of attacking that problem has a full chance to operate.

We know that that method cannot, for a long time, answer the whole problem. For that reason, our organization went on record endorsing the principle of national insurance.

Now, I think that everybody will agree that there is a lot of difference between the proposition of enabling people to pay for their health care, on the one hand, and the personal relationship that exists when that health care is given to people by those qualified to do it. In an insurance field, the broader the coverage can be, the sounder your insurance plan will be, which is an argument for national insurance. But when you come to personal relationships such as are involved in health care, then we think it is most important to emphasize the responsibility of the people concerned and to try to do what we can to encourage their initiative in solving their problem.

We think that that will be just as important, Mr. Chairman and gentlemen of the committee, if the national-health insurance plan is passed, as it is today. I cannot say it will be more important, because, in the absence of that legislation, there is only the reliance we have, which is the initiative of the voluntary organizations of one kind or another; but if national insurance should be enacted, it would then be tremendously important from the standpoint of the country as a whole, I would say, that we lay major emphasis on as much voluntary action in the field of the organization of health care as we possibly can and that we retain the concepts of insurance in its proper field.

Well, now then, we feel, Mr. Chairman, that the problem, particularly in rural areas, is never going to be really solved until it is solved on a community level, and we also know that there have been many efforts to solve the problem on a group health or cooperative basis. In rural areas, we have met with great difficulties for the reason that people do not have the funds in many a local community to obtain the facilities that they need.

Now, there is a tremendous problem of maldistribution of facilities and personnel, as you know. I could give figures, but you have heard them already, and there is no use in going over that again.

The two things that are going to do the most to bring a doctor gladly to a community—not under forced draft, because I do not think that that would do any good—but to bring him there gladly are, first, that he feels a reasonable assurance of a steady income and a decent one, and second, that he has a good modern workshop. Now, I am talking about them both really, because what I want to appeal to the committee to do is to make provision for a system of loans and grants for the construction not only of hospitals, but of clinics and health centers, and to make those available to bona fide group health organizations which are set up on a genuinely cooperative basis and which are prepared to give real comprehensive care to their members and also to the community on a prepayment basis.

In my statement, Mr. Chairman, which we sent out of Chicago on last Saturday, but which I understand from Mr. Reno is not here yet, there is set forth what we think the provisions of that legislation ought to be, but very briefly, I would like to say that I think that the Hill-Burton Act has done much good. I am encouraged, however, over the amendments that are proposed in title III of the omnibus bill, which I think will make it more effective. I still think there is a great need, however, for emphasis upon the smaller facilities. There are a lot of communities where it does not make sense to have a big hospital and where they cannot afford it, and in those communities, if there could be a system of loans or where necessary, grants for clinics and health centers which could then be associated with a hospital in some central community, we believe that it would do more to encourage initiative of the people in working on this problem and taking responsibility for it, and also more for bringing doctors to the communities where they are most needed than anything else we know.

We also would like to point out in the case of a good many union health plans, it is seldom that a union health plan wants to own a hospital; but in many instances you have local unions, small ones, sometimes, with health plans where if they could have a long time loan for a health center, it would mean a great deal to them.

Now, Mr. Chaiman, I think I should quit.

Mr. PRIEST. Mr. Voorhis, we appreciate so very much your statement. Your statement in full may be included in the record.

I have known of your great interest in this subject and of the very long study you have given to it. I appreciate particularly your emphasis on the importance of clinics and health centers in the rural communities. I have felt for a long time that if we could provide some means that would enable rural communities to develop, say, an 8- or 10- or 12-bed health center or clinic, whatever you want to call it, that it would be one of the greatest steps we could take so far as rural health is concerned.

Mr. VOORHIS. I think so.

Mr. PRIEST. I quite agree with you that we should give more emphasis, I think, than we have in the past, to that type of health program.

Are there any questions?

Mr. BIEMILLER. Mr. Chairman, I am very happy to have heard the testimony of Mr. Voorhis here today. Those of us who have worked with him in the House learned to respect both his sincerity and his knowledge of many questions. I gather that Mr. Voorhis might favor an attempt on the part of the committee to consider fusing some of the philosophy behind section 4 of the omnibus bill with section 3, which would, in effect, expand the purpose of the Hill-Burton Act to include small clinics and small hospitals.

Mr. VOORHIS. Yes; that is true. I can be more specific, though, if the Members of the House will not mind my referring to a Senate bill, which is S. 1805, introduced by Senator Humphrey, of Minnesota, which is mentioned in my statement, and outlined in my testimony given in connection with that measure. That bill really incorporates what I have appealed for here this morning.

(The statement above referred to is as follows:)

TESTIMONY OF JERRY VOORHIS, SECRETARY OF COOPERATIVE HEALTH FEDERATION OF AMERICA

This committee has under consideration one of the great underlying problems that affects the lives of every man, woman, and child in America. It is the problem of the Nation's health.

There was a time, not so long ago, when many Americans would have regarded this as an entirely personal matter and one about which Congress should therefore not concern itself. Today all that is changed. We do recognize that the health of the people is a matter of national concern.

The medical profession in the United States has today the knowledge and skill which could render this Nation one of almost generally healthy human beings—if only that knowledge and skill could be brought to bear in the right places at the right times and in sufficient amounts.

We have learned how serious a matter neglect of health can be from the point of view of national security. We have learned that the health of an oncoming generation is not merely of concern to the families in which the children are born but to the Nation as a whole. We learned that poverty and want as well as inability to work steadily are many times traceable to conditions of ill health in the early years of life. We learned the vast importance of preventive as well as curative medical care. We gained a new respect for measures of public health.

The people of America have become health conscious. Whole great farm organizations and labor unions have begun to place measures for the improvement of the health of their members at the very forefront of their programs. A flood of literature on the subject of health has increased the interest of the people and heightened their determination to bring the advantages and blessing of modern medical science within reach of all the people of the Nation.

As with all other great problems, this one does not lend itself to simple solution. The great number of bills that have been introduced, the variety of methods proposed for attacking various aspects of the problem, bear ample testimony to that fact. Powerful arguments can be advanced in support of every title of the so-called omnibus bill as well as the provisions of the many other bills that are before this committee. Nor is it to be wondered at that sharp disagreement has developed as to the particular methods to be used in attempting to solve this or that phase of the problem.

The Cooperative Health Federation of America, the organization which I have the honor to represent here, as its Secretary, is dedicated first of all to the cause of bringing about improvement in the health of the whole of the American people—by whomever and by whatever means that can be accomplished. The Cooperative Health Federation of America numbers in its membership 21 regular member organizations and 30 associate members. The member organizations include most of the successful group-health plans in the country. These range all the way from health insurance companies on the one hand to cooperative hospitals and complete service plans on the other. The associate members include farm and labor organizations, regional cooperatives, and other organizations, whose membership is composed of consumers of health care.

Thus it will be understood why our organization is deeply interested in the stepping up of hospital construction, in the forwarding of medical research, in increasing facilities for the training of more professional medical personnel, in the strengthening of programs of public health, and in the solution of the problem of enabling people generally to have access and to pay for adequate preventive as well as curative medical care. This last problem can only be solved satisfactorily by a broad application of the principle of insurance.

But the reason for existence of the Cooperative Health Federation of America is the promotion of voluntary action by groups of people to meet together health care needs which they cannot meet individually. No one family in a county that has no medical facilities nor more than one or two doctors can possibly solve its own health problem. But if a considerable number of families in that area join together cooperatively and agree to pool their common need for health facilities, for doctors, for preventive care, and for care in the face of catastrophic illness, then all these families together can meet that common need. For they can then prepay at rates not difficult to determine the average cost for the group of adequate health care. They can then assure doctors of reasonable income from steady practice. They can demonstrate the need for and ability to pay for certain specialists in addition to the general practitioners.

It is possible, as has been proven already in many parts of the country, for a common unfilled need to be met if people will join together to provide themselves with the services none of them alone can either afford or command. To tell the story, to guide the organization of health cooperative groups, to encourage the adoption by them of the highest medical and ethical standards—these are the tasks our organization has. We have deep and abiding concern about all phases of the Nation's health problem, and the committee will, I am sure, understand why we believe that the best type of solution, insofar as it can be applied, is the cooperative one—the one whereby the people act together cooperatively on their own behalf.

A democracy is strong to the extent that its people have and exercise the faith that they can solve problems by their own efforts. If all of us believed strongly and sincerely enough in the democracy we profess and if we worked at it hard enough in the local communities where we live then the health problem, like many others, would be largely solved by the springing up all over the Nation of voluntary cooperative group health organizations. And these would not only solve an economic problem, but they would do it in a way that would draw people closer together, that would make the word "community" mean what the dictionary says it means, that would call forth the strongest qualities of character from each of us and the ones most necessary to a virile democracy in the Nation.

It is too much to hope that such a resurgence of the democratic spirit will take place overnight. Nor can it be forced by the passage of legislation or otherwise. This is one of the main reasons why the Cooperative Health Federation of America passed at its last annual meeting a resolution reaffirming its support of the general principle of national health insurance. But it is encouraging that in many places the people are attempting to solve their problem of health economics by cooperative methods right now. We have come before this committee to urge passage of legislation to give impetus to this development.

The problem may be stated very simply. While there is a widespread desire on the part of large and important groups of people in both rural and urban areas to form voluntary prepayment plans, the organizational effort usually meets with frustration because of inability to raise the necessary capital for the physical facilities. Many groups of people have attempted to organize these plans by raising the money from their own resources. Sometimes they have met with little success. When they have attempted to obtain financing in the usual channels they have found that financial institutions and insurance companies are not interested. The need is clearly indicated for Federal assistance, such as has been provided in rural electrification. The principle here is that Federal financial assistance through use of the people's own credit shall be available to groups which demonstrate that they can and will organize and join together on their own behalf. And we would add and underline that the main encouragement should be given to cooperative groups prepared to provide comprehensive care on an orderly prepayment basis.

In many cases the need can be met by long-term loans at a low rate of interest. In some areas, however, outright grants will be required. If the capital needs for the physical facilities can be obtained, then in many instances at least these local plans can meet their current operating costs from their own revenue.

In rural areas the great problem is improving the distribution of medical care—bringing the doctor to the people. The method so far most successful in accomplishing this end is for the local community to organize itself to obtain the necessary funds for, (*a*) providing a modern medical workshop which will induce physicians to locate in the community and, (*b*) a sustained common pool of funds provided from prepayments which will assure adequate income to the physicians in bad times as well as in good. In the urban areas there are many instances where labor unions have considerable health and welfare funds which they desire to employ in arranging for the provision of group medical care. Here again, the great barrier is very often the inability to finance the acquisition of a health center or clinic.

To operate a prepayment medical care program successfully, it is essential to provide good clinic facilities. Such facilities are the doctor's workshop and without them he cannot do an adequate job of medical care. When such facilities are not available, it is most difficult to induce good physicians to come to a community to practice. In many rural areas and in smaller communities where adequate hospital facilities are not available the prepayment medical care plan may need also to provide some minimum hospital facilities to take care of minor medical and surgical cases.

The problem of financing the development of clinic and hospital facilities in many instances has effectively blocked the development of prepayment medical care plans. Many community groups could support such plans once they were set up. It is the raising of the initial capital that often proves the barrier. Present legislation such as the Hill-Burton Act provides only for hospital construction and gives no assistance for clinic facilities.

Many rural communities have not been able to take advantage of the Hill-Burton Act because they could not afford hospitals of the very fine standards required—or else because they couldn't afford hospitals at all but needed facilities of a less expensive type. In the case of union health plans the principal need is clinical facilities and hardly ever for full-scale hospitals.

The amendments to the Hill-Burton Act proposed in the omnibus bill title III are, in many respects, good ones, especially the provision making possible a larger percentage of Federal contribution for hospital construction in the case lower income areas. But we are fearful that these amendments will still leave what in many communities is the first need unmet—namely, the need for clinic and health center facilities. It is true that section 305 provides that State plans shall set forth the extent to which they may include construction of facilities other than hospitals. But this is all very vague and far away. Furthermore the entire act which title III would amend refers throughout to typical hospitals and all its provisions are geared to them. It appears to us that considerably more amendment would be necessary if practical results in the form of clinic and health center construction are to be obtained.

We believe the rural health problem particularly will never be fully solved unless it is solved at the community level. Hence the proposal of the Cooperative Health Federation is that a simple piece of legislation be passed which would provide Federal assistance in a single package of loans or grants for facilities and would clearly make such assistance conditional upon the organization of an effective and genuinely cooperative, comprehensive, health service plan by the people themselves.

This proposal is incorporated in a bill which Senator Humphrey, of Minnesota, has introduced and which bears the number S. 1805. But we see no reason why it could not with perfect logic be included in this omnibus bill as a projection of the objectives sought by title III. It might be an additional title or, if it were made clear that it was not carried as an amendment to the Hill-Burton Act, it could be added at the end of title III.

This measure would briefly provide:

(1) Federal grants or long-term loans, or a combination of both, to pay part or all of the cost of acquiring, constructing, and equipping clinic and health center facilities.

(2) Such grants or loans to be made available to cooperative or nonprofit associations which will provide: (*a*) Sufficient prepayment income to cover operating costs; (*b*) democratic selection by the membership of the governing board, not more than one-third of which may be physicians furnishing the medical care; (*c*) assurances that the lay management will not interfere in the practice of medicine; (*d*) that so far as practicable the prepayment plan will provide comprehensive service, including preventive as well as curative care through group practice; (*e*) voluntary participation on the part of both the members and the physicians.

(3) The administration of the appropriated funds would be in the hands of the Surgeon General under the Federal Security Administrator, in order to assure efficiency and low cost of administration. In view of the relatively small appropriation requested, it would seem unwise to delegate administration to the States and thus increase the costs of administration. We believe that the administration of this program should not be appended to the hospital survey and construction administration, for the further reasons that the facilities are not hospitals in the strict sense. The Hill-Burton Act refers throughout to hospitals, as do many of the State acts which augment and implement the Federal law. Thus, if administration of our proposed program were to be appended to the Hospital Act, conceivably it might require several years to obtain accommodating State laws.

(4) The Surgeon General would formulate standards for the allocation of the funds for the making of grants or loans on the basis of relative economic status of the area or section involved, and other relevant factors.

(5) The grants and loans would be made available only to applicants in States which permit cooperatives or nonprofit associations to own and operate health facilities and to furnish medical care for their members.

(6) We believe that there should be a minimum appropriation of $25,000,000 per year and recommend that the program be set up for 5 years. It is estimated that this amount will provide the necessary assistance to about 250 plans, or approximately five plans per State annually. The great number of requests for guidance in organization constantly received by our federation, clearly indicates that Federal assistance will assure the rapid and sound development of voluntary medical service plans throughout the country.

The objectives of such legislation will, I am sure, be clear to the committee. The basic aim is to encourage groups of people to take direct responsibility for the solution of their health-care problems. The bill would not offer assistance unless and until an organization of the people in need of more adequate health care or living in an area of shortage of personnel and facilities had developed a sound plan for their own benefit and won the approval of the Surgeon General for it. But the point is that in many of the communities having greatest need and where there is the greatest readiness to act on their own behalf there simply is not the income necessary to finance facilities essential to a health program or to attract doctors to that area. The bill would remove this obstacle. It would apply the same general principle that has brought electricity to rural America to bringing adequate health care to rural and other communities which have need. The bill is thus a direct attack upon the problem of maldistribution of our professional personnel and facilities.

It is, we believe furthermore, an absolutely essential addition to legislation now on the statute books and even to other legislation now proposed. And for two reasons. In the first place, S. 1805 is not limited to hospital construction. Health centers and clinics could also be constructed under its terms. In many a rural community the people cannot and ought not to try to afford a complete hospital. But they can afford a clinic or a health center. Second, the bill would make available, if need be, a combination of low-interest loans and grants. This is the feature that will make its benefits available to communities which cannot afford adequate facilities of any sort and also pay the current costs of medical care even on a prepayment basis. It is contemplated that loans would be employed wherever possible, but that where it is evident that the income of an entire group of people is so below the average of income for the Nation as to justify such action then part or all of the money would be made available in the form of a grant.

While I have spoken at some length of rural areas since the most acute shortages exist there, the terms of the bill by no means limit its application to rural communities. Its provisions apply equally to industrial areas where plans might be, or are already organized and where need for assistance is evident. Many a labor union health plan would be greatly helped by the passage of this legislation. A well-equipped health center is frequently their greatest need.

Moreover under the terms of S. 1805 loans and grants could be made only to genuine and effective cooperative and nonprofit plans, the basic features of which are carefully defined.

We believe one of the greatest needs of today and one of the necessary prerequisites to succesful operation of a health-insurance program is the construction of adequate health facilities where they do not now exist. Hence our great interest in the subject matter of title III. Needless to say we do not contend that the particular provisions I have set forth constitute a cure-all or anything approaching it. But we do believe they are sound measures from every point of view. They attack the central problem of all—namely, the problem of whole communities whose total income simply is not enough to pay for adequate health care and to finance necessary facilities at the same time. And they attack it by helping out in one clear-cut concrete manner rather than by any form of continuing subsidization. They propose to help with the cost of facilities and by that means to bring the over-all costs of prepaid medical care within reach, or at least more nearly within reach of such communities. And they would do this only where the people themselves have taken the initiative and organized a plan for the solution of their own problem.

I know quite well the problems that surround the legislative process in the Congress. I know that democratic government is to a large extent a business of synthesis and compromise. I realize that a great number of bills containing many worth-while provisions have been introduced and are before this committee. It has been quite impossible for us to examine with care all of these bills, particularly since by far the major part of our organization work is in the field with the actual operating plans throughout the country.

So in conclusion let me make it clear that our appeal is twofold. First, that Congress not adjourn its present session without taking some constructive action in this vital field of the Nation's health. And second, that the most careful consideration be given to our contention that one of the most logical types of legislation and one for which widespread support can be enlisted is that which has been outlined in this statement.

Mr. Voorhis. Thank you.

Mr. Priest. Thank you, we are mighty happy to have had you, Mr. Voorhis.

Mr. Priest. At this point, the Chair will ask unanimous consent that a statement by Hon. Harold A. Patten, a Member of Congress from Arizona, be included in the record, and statements from

Hon. Albert Rains, Hon. J. Glenn Beall, Hon. Wayne N. Aspinall, Hon. Harold C. Hagen, Hon. Peter W. Rodino, Jr., Hon. J. Hardin Peterson, Hon. Dixie Gilmer, Hon. Laurie C. Battle, Hon. Reid F. Murray, Hon. W. F. Norrell, Hon. Thomas A. Jenkins, Hon. Wesley A. D'Ewart, Hon. Robert L. F. Sikes, Hon. Francis Case, Hon. Charles B. Deane, and Hon. Chester E. Merrow.

These statements will all be included in the record.

All of these statements are in support of one or more of the bills before the committee this morning.

(The statements above referred to are as follows:)

STATEMENT OF HAROLD A. PATTEN, MEMBER OF CONGRESS FROM ARIZONA

Mr. Chairman, I should like to discuss the hospital conditions in the State of Arizona. Arizona, as you know, is primarily rural, and the small rural communities, which are chiefly in need of hospital services, do not have the economic and financial resources to finance 66⅔ percent of the cost of constructing and equipping small hospitals or community clinics. Hospital construction costs remain very high. Present cost estimates are $15 to $17 per square foot for construction plus approximately $1,000 to $1,400 per bed for group I, II, III equipment or approximately $14,000 per bed to build and equip the hospital, so that it is ready to receive patients when completed.

In designing a small hospital architects generally assume that the minimum floor area of the building will be at least 600 square feet per bed. There seems to be a slight downward trend in contractors' bids on the construction of school buildings. Hospitals, however, need so much plumbing and specialized equipment that there is no noticeable reduction in costs.

The Hill-Burton Act quite wisely sets up standards for hospital design and services. There is little point in spending public money to build substandard and poorly equipped hospitals which will in the end give inadequate hospital service to the community.

Specific instances of the financial limitations of the rural areas in Arizona to build hospitals under the present program are the towns of Williams and St. Johns. The town of St. Johns is 64 miles from the railroad and has no available hospital facility or maternity home. The latest statistics give a population of 1,700. The Valley National Bank report shows the 1947 total retail sales at St. Johns were $875,155, which is 1.5 percent of the total retail sales of the State.

Last summer a community hospital committee was organized by the chamber of commerce. This group made a study of the hospital needs of the vicinity, secured contributions from public-spirited citizens, and as a start toward a small community clinic bought two surplus hospital buildings from the Kingman Army Air Field, which were knocked down and shipped to St. Johns together with plumbing and light fixtures. One of the highway engineers, using a standard design prepared by the United States Public Health Service, drew the plans for the building. However, there simply was not enough money to have the hospital constructed by contract.

Using the figures given above, 16 beds requiring an area of 600 square feet per bed would make a total of 9,600 square feet. The cost at $15 per square foot would be $144,000. This would mean an average cash contribution of $84 per capita and you know isolated rural communities cannot do this. Therefore, being enthusiastic and willing, they took contributions of materials and labor, as well as money, and have constructed a hospital building largely by voluntary labor. Now, they need heating plant, special plumbing fixtures for operating and delivery room, kitchen, and so forth. They must also purchase the furniture for the hospital, including expensive specialized equipment, bedding, china, silver, and other "nonexpendable" hospital supplies. They have three beautifully typed lists of items required to make the building an operating hospital. The community does not have the cash for one-third of the 66⅔ percent they are required to have if they receive Federal assistance to purchase the equipment.

With sharpened pencils, the committee figures that they probably could make the grade if they only had to have one-third cash of 43.3 percent of the total cost of equipment and nonexpendable supplies needed. Arizona's allotment percentage is 56.7 percent.

A small remodeled residence now serves as a hospital for Williams. According to the State's licensing regulations this is nonacceptable both from a structural standpoint and the method of operation. Like St. Johns, Williams did not have enough money to let a contract for the construction of the new hospital. The city passed a bond issue for $60,000, which is the limit allowed by law. Interested firms have donated carloads of building materials and a number of citizens have contributed hours of labor to help with the building. By the 1st of July the last of their cash will have been used to complete the structure which will then provide 16–20 beds for patients. There will be no money left, however, to equip and furnish the building. They think a fund-raising campaign might bring in approximately $4,000. The bare minimum for equipment will be $16,000. Williams has a population of 3,000. Retail sales in 1947 were $2,190,037, which amounts to 3.1 percent of the total for the State.

A year ago citizens of Buckeye (near Phoenix) began to plan for a small community clinic with 12 beds. About the same time the Casa Grande Valley Cooperative Community Hospital Association was formed in an effort to secure adequate hospital facilities for Casa Grande, and the surrounding farm country. To date neither community has been able to raise enough funds to meet two-thirds of the cost of the proposed hospitals.

This indicates the trend of hospital construction needs in Arizona and, as you can readily see, there is a great need that cannot be met by the State or local communities. It is imperative that more Federal funds be made available as quickly as possible, and I trust that the committee will report favorably on this measure. For your further consideration, I submit additional facts and figures on the need for beds and hospital space in Arizona.

Current status of hospital construction program in Arizona

1947–48	$451,739
1948–49	443,109
1948–50	[1] 402,956

[1] Tentative.

PROJECT CONSTRUCTION APPLICATIONS APPROVED FOR 1947–48 ALLOTMENT

Project	Total	Federal
Maricopa County Hospital, Phoenix	$497,748	$165,916.00
St. Mary's Hospital, Tucson [1]	1,472,000	240,426.66
Pinal General Hospital, Florence	45.000	15,000.00
Total		421.342.66

PROJECT CONSTRUCTION APPLICATIONS APPROVED FOR 1948–49 ALLOTMENT

County General Hospital, Globe	$450,000	$150,000.00
Santa Cruz County Hospital, Nogales	450,000	150,000.00
Total		300,000.00
Balance		143.109.00

[1] Federal funds ⅓ of 49 percent of total.

Hospital projects under discussion:

Group I, II, and III equipment for St. John Community Clinic: total group I equipment, $19,472.85; lists of group II and III equipment not completed.

Group II and III equipment for Williams Community Hospital: lists not completed, approximate cost $28,000.

New Yavapai County Hospital, Prescott: to provide 24 beds for tuberculosis, 6 beds for isolation and 15 surgical and medical and 9 obstetrical; approximate total cost, $500,000; Federal funds, $166,700.

Extension of service facilities at Pinel General Hospital, Florence: in addition to the construction of four 4-bed wards now approved, the county contemplates increasing and improving dietary department; provide emergency room; additional laboratory and storage space; new central sterilizing and supply room; staff lockers, etc. No estimate of cost received.

Addition to Arizona Tuberculosis Sanatorium $1,125,000 (estimated) and State laboratory, estimates: 1950–51, $167,500; 1951–52, $167,500.

Hospitals have been proposed and are badly needed in the following places, but no information has yet been received on proposed construction plans: Graham County General Hospital, Safford; Valley Community Hospital, Buckeye; Casa Grande Valley Cooperative Community Hospital, Casa Grande.

One-third of the applicant's resources, as shown on part 2 project construction application, are required to be liquid and free from any claims or encumbrances at the time part 2 is submitted.

Figures on civilian hospitals in Arizona in terms of needs and existing facilities as prepared by the State Health Department July 1, 1948, show:

Type of hospital service	Total needed	Total in operation	Total planned
	Beds	*Beds*	*Beds*
General	3, 627	2, 557	1, 070
Mental	3, 245	1, 250	1, 995
Tuberculosis	1, 554	559	995
Chronic	1, 298	44	1, 254
Total	9, 724	4, 410	5, 314

The State health department has also recommended a total of 21 health centers in addition to the four currently in operation.

STATEMENT OF HON. ALBERT RAINS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ALABAMA

Mr. Chairman, bills now pending before your subcommittee, one of which I introduced, would amend the Hospital Survey and Construction Act, commonly referred to as the Hill-Burton bill, which was passed by the Seventy-ninth Congress.

Among other things, these bills seek to increase the authority of the Surgeon General for hospital construction grants from $75,000,000 to $150,000,000 annually; also to extend the duration of the act for 4 years. Several of the pending bills before this committee, if enacted into law without amendment, would work great inequity and discrimination against hospital projects which were approved before January 1, 1949. With that thought in mind, I have introduced H. R. 3515, which would make retroactive the increased grants in order that those communities who have sacrificed so heavily might receive the benefits, to which they are justly entitled, of the pending and more liberal legislation.

I urge the adoption of legislation providing for the increased Federal participation in the hospital program, and trust that the committee will see the justice and wisdom of giving the benefits of this more liberal program to those communities who have already qualified under the terms of the present law.

STATEMENT OF CONGRESSMAN J. GLENN BEALL, IN BEHALF OF H. R. 3737

Mr. Chairman, I am appearing in behalf of H. R. 3737 which protects those few hospital projects approved before January 1, 1949, and which will be denied benefits of the more liberal hospital construction grants proposed by House bills 2176, 2567, 3025, and S. 614.

The Garrett County Hospital located at Oakland, Md., in my district, is one of those approved prior to January 1, 1949. The estimate approved by the Surgeon General of the United States and the Maryland State Department of Health provided for a total expenditure of $515,000 of which one-third or $171,666.67 was set up as the Federal share and two-thirds or $343,333.31 was raised by the community. The contract was let on August 10, 1948, and construction was started approximately 10 days later but due to bad weather during the winter months construction was slow; nevertheless the building is now one-third completed.

Under S. 614 grants for the 10 completed projects and those 188 projects which received final approval for the letting of contracts before January 1, 1949, would remain at one-third of construction cost. This would mean that those communities which went out and raised money for a definite hospital program and started work at an early date would be penalized and those going into construction after January 1 would receive in excess of one-third of construction costs.

I feel that the proposed liberalized grant percentage should be made retroactive to take care of cases such as the one in my district. I sincerely hope that H. R. 3737 will be approved in order that the projects approved before January 1, 1949, will be allowed the same benefits as those projects approved later.

Statement of Congressman Wayne N. Aspinall in Support of H. R. 3737

Mr. Chairman, my name is Wayne N. Aspinall. I am the Representative to the Eighty-first Congress from the Fourth District, Colorado. I reside in the town of Palisade, Colo., just 13 miles east of the city of Grand Junction, Colo., which is the largest city between the city of Denver, Colo., and the city of Provo, Utah.

The city of Grand Junction is the most influential trade center of all that area lying between the Continental Divide on the east and the Wasatch Mountains in Utah on the west. The only other city of comparable influence in such area is Price, Utah, which is situated in the foothills on the east of the Wasatch Range. With the exception of an approximate 50-bed hospital at Price, Utah, the city of Grand Junction affords the only general hospital facilities to this large area which is some 400 miles in length and 320 miles in width. I do not mean to say that there are no other hospitals in this area but I do want to convey the thought that the only hospital which gives general service and which uses extensive and modern equipment is the one located at Grand Junction, Colo.

The hospital which has been and is now being operated in this city belongs to and is under the supervision of the Sisters of Charity of Leavenworth and presently provides about 80 beds. It has been so limited in its services that, immediately after it was recognized that the Federal Government would, more than likely, give some aid to the constructing and equipping of new hospitals throughout the Nation, the residents of this area embarked upon the program of constructing a new hospital and bringing to it modern and up-to-date equipment. After a survey of the community and because of the fine record that has been made by the Sisters of Charity in the operation of St. Marys Hospital (the one above referred to) it was decided to cooperate with them in their efforts to build a new hospital for the district. Accordingly, a fund raising campaign was decided upon and $200,000 was raised by popular subscription. A bond issue is not possible in this instance.

The current financial program of the new hospital, construction and equipment, in Grand Junction which takes into consideration the benefits of the Federal law now in effect, provides for a total cost of $2,100,000. This is broken down as follows: Construction program, authorized by contract, $1,876,000; equipment, architect fees, landscaping, etc., $250,000. These items, however, do not include the total number of expenditures contemplated for the completed project. They represent only what the Sisters of Charity, with presently available funds, are able to take care of at this time. In other words, it represents a program made possible by the $200,000 popular subscription, the amount made available by Federal grant under existing law and the funds which the Sisters of Charity have available and have been able to borrow.

As the project now stands, a considerable part of the hospital, now needed, will be left unfinished until a future date and much of the vitally needed equipment will have to be delayed in purchase, unless the provisions of H. R. 3737 are made available to projects which were authorized before January 1, 1949.

The original work on financing the new St. Marys Hospital at Grand Junction, Colo., was started in 1946. Actual bids for construction were taken in November 1948. The contract was let prior to January 1, 1949. Work on the project started in February 1949, and it will not be completed until November of 1950. I am advised that the original plans are so made that the additional facilities required may be constructed at any time, that is, immediately or at a future date. However, as the program is now contemplated, such construction will be postponed.

If H. R. 3737 becomes law, the new construction could be had at once and make possible the completion as one unit of the whole project, as originally planned. In other words, there would be no overlapping of construction work whatsoever and in the procurement and placement of new equipment, some money and much time would be saved.

St. Marys Hospital, as it has been operated in the past and is now being operated, and as the new hospital itself will be operated in the future, serves all the citizens of western Colorado and a large part of eastern Utah. This entire area is underserviced insofar as hospital facilities are concerned. The additional Federal funds which would be provided under the provisions of H. R. 3737 are desperately needed and in all fairness it appears that the Sisters of Charity, the doctors and nurses and the citizens of this large community should not be penalized because the contract for the construction of the hospital was let some month or month and one-half prior to January 1, 1949, the date provided for in H. R. 2176, 2567, 3025, and S. 614.

Mr. Chairman and members of the committee, it is my opinion that one of the most important of all secondary governmental services rendered to the people of our country is the making possible of the construction and operation of well-staffed and equipped hospitals throughout the Nation. This program is one of our most effective methods of combating any un-American "ism" or ideology. I desire to state my continuing support of such legislation. I feel that the equities in the matter under consideration call for the approval of H. R. 3737.

Statement by Hon. Harold C. Hagen

Mr. Chairman and members of the subcommittee, I have asked for time to point up my keen interest in this bill, H. R. 3737.

Besides recognizing the need for expansion of hospital facilities in our country—as I am sure all of you do—I am interested in several projects in my district for which funds were appropriated through Public Law 725 of the Seventy-ninth Congress.

A good example is the hospital being built at Greenbush, Roseau County, Minn. This hospital should be completely constructed by October 1 of this year. At this time, it is about 60 percent complete.

The estimated cost of this hospital was $210,683, with a Federal contribution of $69,246, through Public Law 725. This means the village of Greenbush had to contribute $151,437 toward construction of the hospital. They were able to raise most of the money, but had to issue debenture notes in the amount of $40,000 for the balance.

The village of Greenbush has approximately 600 people living in it. But it is centrally located in a large farming area, and time has proven the need for a hospital in the community.

From the figures I have mentioned, you can readily see that the Greenbush community has done a wonderful job of raising funds for this project, over a hundred thousand dollars. This was done through the help of everyone; individuals in towns, individuals on the farm, civic organizations, fraternal clubs, churches and church groups, veterans clubs, and farm organizations.

Because they showed initiative, perseverance, and courage, and got their project started prior to the first of this year, they certainly should not be penalized. They should be given the additional help that can be provided through this bill, H. R. 3737.

Mr. Chairman, it is my sincere belief and hope that this bill should be favorably reported by your subcommittee.

My thanks to you all for the opportunity of appearing before you.

Statement of Representative Peter W. Rodino, Jr.

Mr. Chairman, the city of Newark, N. J., which is part of the Tenth United States Congressional District of New Jersey, is a melting pot of approximately one-half million people. These people come from all walks of life. Like many other cities, we have our rich and poor and our middle class. Many of these people are in need of medical attention and hospitalization. Some are financially able to provide this care for themselves. Many are not. Our city has tried to minister to the health needs of the indigent through the Newark City Hospital, which was erected more than 50 years ago. However, we have not been able to do this work effectively because the Newark City Hospital is not adequate in many respects.

The medical board of the city of Newark and our Newark public officials have for a long time been pressing for the construction of a new hosptial—one which can adequately meet the needs of our city's indigent cases. However, lack of funds has made this project only a hope instead of a reality.

I know from personal experience and observation of the overcrowded conditions at the Newark City Hospital. I know, too, that it is an antiquated, outmoded and obsolete structure which menaces and jeopardizes the lives of the patients who are compelled to be hospitalized therein. In my opinion this 500-bed capacity hospital which ministers to the needs of a 725 case load makes good medical and nursing care impossible. Our citizenry is aware of these conditions. And when its poor, who have no other place to go to for hospital treatment, are ordered there they despair.

The taxpayers of our city, who are already overburdened, would like to do their just share to remedy this condition. They would like to see a new hospital constructed. But the estimated cost of a new and adequate hospital under present economic conditions is so prohibitive that it has precluded construction.

Because of the priority clasification under which the Newark City Hospital has been placed, it has been impossible to aid the city of Newark under existing legislation, Public Law 725, Seventy-ninth Congress. However, should more funds be made avaialble by increasing the allocation of Federal grants-in-aid, the city of Newark will be in a position to undertake the construction of a new hospital.

The city of Newark makes up only a small part of the United States. But recent surveys indicate that the need exists all over for additional health facilities. State plans estimate that to provide adequate health care, an additional 897,000 beds are needed. In order to be able to accomplish this, it will be necessary to increase the Federal share in the cost of projects over and above the present one-third which the Government now grants.

But State agencies lack the financial ability, even with present Federal aid, to construct and maintain a hospital.

I strongly urge, therefore, that the present existing legislation be amended so that the present program may be extended, and Federal allotments be increased to meet the health needs of our Nation.

I would like to include herein, a statement by Stephen J. Moran, director of the department of public affairs, city of Newark, N. J., together with a report by the medical board of the Newark City Hospital.

STATEMENT BY STEPHEN J. MORAN, DIRECTOR OF DEPARTMENT OF PUBLIC AFFAIRS, CITY OF NEWARK, N. J.

Modern public hospital structural facilities are urgently needed in the city of Newark, State of New Jersey, a highly industrialized and cosmopolitan municipality with an estimated population of 450,000 persons.

The Newark City Hospital with a 500-bed capacity has an average census of 725 bed patients. The overcrowded condition in this institution seriously impairs the effectiveness of the hospital care and treatment of these indigent patients, and still worse, due to the obsolescence of the physical structure their very lives are in constant jeopardy.

The building which was erected more than a half century ago is a truly menacing fire-hazard. It is utterly inadequate and unfit for housing the ever-increasing numbers of bed-ridden patients therein. The local private hospitals are unable to find room for the excess patients referred to them by this municipally operated institution. In consequence we are compelled to crowd our patients into already congested wards, put beds in the corridors, in the sun-rooms and in every other available space.

Aside from the potential danger to life and limb, proper segregation of these patients in line with best modern hospital practice is impossible.

Herewith I am submitting for your information the recommendations contained in a special report by the medical board of the Newark City Hospital addressed to the Citizens' Advisory Committee. I respectfully commend their views and recommendations to your earnest attention.

I am making this appeal on behalf of my city for substantial Federal and State aid, pursuant to the passage of the proposed amended Federal legislation which I strongly urge as a vital necessity in our specific case. The public hospitalization situation in Newark is very bad and is getting cumulatively worse.

Prevailing economic conditions obtaining now in Newark preclude the possibility of financing the costruction of a much-needed new local public hospital. The estimated cost which the city would be called upon to bear under existing legislation, as per Public Law 725, Seventy-ninth Congress, is prohibitive, and far beyond the financial capacity of our already overburdened taxpayers.

NEWARK CITY HOSPITAL,
Newark, N. J., February 8, 1947.

Mr. THEODORE SORG,
Chairman, Subcommittee of Citizens Advisory Committee,
Newark, N. J.

DEAR SIR: At a special meeting of the Medical Board of the Newark City Hospital held January 30, 1947, Dr. Edward Sprague asked the board to submit to your committee its views and recommendations, or its answers to four specific questions.

No. 1. As to the need for a new city hospital.

We reemphasize our oft-repeated statement that the present structure is outmoded, obsolete, not fireproof, and is inadequate in size and in design for the proper care of the indigent sick.

Its lack of fireproof construction could result in a definite menace to the lives of the inmates and its constantly overcrowded condition makes good medical and nursing care difficult and at times impossible.

It is our considered opinion that no amount of remodeling could rehabilitate our old hospital so that it would measure up to present-day demands and standards of hospital design and construction.

No. 2. As to site.

We believe that it is essential that the new hospital be constructed in the immediate vicinity of or directly adjacent to the present structure. If rehabilitated, part of the present structure could be used as an out-patient department, clinics, and so forth, as further outlined in question 4. The present north wing could be used to house the chronic cases now totaling between 100 and 150 in the hospital. The tuberculosis patient might very properly be housed in south wing, rather than in new hospital. There are many other possible uses to which the present structure might be put, and we suggest this question be gone into in detail later.

No. 3. Number of beds recommended (in the combined new structure and present building if rehabilitated).

We fix this figure at 950. Our average daily census is 725. There are always some cases that have to be assigned to other hospitals, because no beds are available for that type of case or because of sex. The peak load in the hospital was 768 with over 300 cases assigned to other hospitals. This was during the depression, and other hospitals then had much available bed space. Nevertheless there were more than 1,068 indigent patients hospitalized as municipal wards.

Most hospital administrators are agreed that the ideal normal load is 80 percent of the bed capacity of a hospital. With our average census of 725 this would call for over 900 beds.

The attached charts show the number of beds by wards and services and sex. The estimated number of beds needed on each service (male and female) appears in last column of table No. 2 and totals 997. These figures represent the opinions of the heads of various services, the hospital administrators and the superintendent of nurses. The greatest and almost constant overcrowding occurs on female medical ward 10, on female surgery ward 16, and wards 13 and 18 for psychopathic and alcoholic cases. Ward 13 with 11 beds, female, and ward 18 with 18 beds, male, must harbor the insane, the alcoholic, police prisoner cases, and juveniles as well as any sick person developing delirium who must be segregated from other patients, all in one ward.

Due to constant overcrowding on wards 13 and 18 psychopathic cases sent in for observation and commitment frequently must be hurried out within 24 hours of admission, thus being deprived of the opportunity of being studied and observed over a proper period of time.

We recommend 25 to 30 beds for females and 35 to 40 beds for males, to be divided into separate wards for psychopaths, alcoholics, police cases, juveniles, and noisy deliriums in the acutely ill.

The medical board, the medical director, numerous grand juries, and other inspecting bodies have repeatedly pointed to the need for remedying the conditions found on these two wards, and since there are no facilities available in any other hospital in this community for these cases, it has always been an important but hitherto unsolvable city hospital problem, and a municipal problem demanding immediate action.

With all the above facts in mind we believe that a bed capacity of 950 is indicated.

No. 4. Need for out-patient department.

This question can be solved by transferring the city dispensary presently located in the board of health building to the city hospital.

Upon motion duly made and seconded, the medical board of Newark City Hospital adopted the following resolution by a unanimous vote; be it

Resolved, (1) That we urge the erection of a new city hospital; be it further

Resolved, (2) That the new hospital be erected in the immediate vicinity of the present structure; be it further

Resolved, (3) That the bed capacity be 950, including present rehabilitated facilities; be it further

Resolved, (4) That Newark city dispensary be transferred to city hospital as the outpatient department.

In addition to the above answers and explanations there are many details that should be discussed, and we recommend that conferences be arranged between you committees and the medical board.

Very truly yours,

DAVIS A. KRAKER, M. D., *President, Staff.*

STATEMENT OF HON. J. HARDIN PETERSON, OF FLORIDA, IN FAVOR OF H. R. 3737

Mr. Chairman, I am making this statement in behalf of H. R. 3737, which liberalizes the Hospital and Construction Act of the Seventy-ninth Congress. I would like to endorse the retroactive feature of this bill, as it seems only fair to encourage and assist those communities who have already taken the lead in creating hospital construction and planning programs. This would further enable the smaller communities ultimately to have more adequate hospital facilities to meet their requirements, and to have facilities equal to those of communities of equal size, who make application after January 1, 1949.

In my own district, the First Congressional District of Florida, the Polk County Hospital in Bartow, Fla., has received approval of the initial application for expansion and alteration, which will provide 70 additional beds and out-patient facilities. If H. R. 3737 is passed, giving additional Federal aid, it would greatly facilitate the completion of these improvements which are so badly needed at the present time.

Also the American Legion Hospital for Crippled Children, St. Petersburg, Fla., would, under this amendment, be assisted in the construction and equipping of a modern fireproof hospital to replace their present wood frame, two-story, converted residence, which is so inadequate to their needs. Mr. Robert G. Carter, supervisor of the hospital planning division of the Florida State Improvement Commission, will, I believe, give details of this project, so I mention it briefly.

I would like to include for the record a copy of a telegram received from Hon. W. T. Edwards, chairman of the Florida State Tuberculosis Board, which emphasizes the need for additional assistance to our State.

In view of the benefits to be derived throughout our State and the entire Nation from the passage of H. R. 3737, I would like to urge favorable action by the committee.

TALLAHASSEE, FLA.

HON. JAMES HARDIN PETERSON,
Member of Congress,
House Office Building,
Washington, D. C.:

An informed Public Health Subcommittee will hold hearings Wednesday and Thursday on H. R. 3737 introduced by Charlie Bennett. Passage of H. R. 3737 will mean over $800,000 to Lantana Tuberculosis Sanatorium now under construction which funds may be used for constructing critically needed additional beds for tuberculosis patients. Please represent Florida Tuberculosis Board and State Tuberculosis Association before House subcommittee and recommend provisions of H. R. 3737.

W. T. EDWARDS,
Chairman, State Tuberculosis Board.

Statement of Hon. Dixie Gilmer, Representative From Oklahoma's First Congressional District

The Seventy-ninth Congress, through the provisions of the Federal Hospital Survey and Construction Act which became effective August 13, 1946, provided for Federal grants-in-aid to pay one-third of the cost of planning, constructing, and equipping new hospitals and health centers.

Through this program, grants have been approved for the construction and equipping of 755 hospitals and health-center projects as of March 31, 1949.

H. R. 2176, H. R. 2567, H. R. 3025, and S. 614, now being considered by the Eighty-first Congress, would amend the 1946 act of the Seventy-ninth Congress by (1) increasing the Federal funds available for these grants-in-aid from $75,000,000 annually to $150,000,000 annually, (2) extending the duration of the act for 4 years, and (3) making grants in each State equivalent to the State's allotment percentage for all projects approved on or after January 1, 1949, instead of the one-third provisions of the 1946 act. There are a number of hospitals that received their grants-in-aid, under the 1946 act, prior to January 1, 1949.

I favor H. R. 3737 because its provisions are made retroactive to August 13, 1946, which I think is only fair and reasonable consideration to those hospitals that have accepted grants-in-aid prior to January 1, 1949.

I, therefore, urge favorable action by your subcommittee and, later, by the full committee on H. R. 3737.

Statement of Congressman L. C. Battle on H. R. 3737

Mr. Chairman and members of the committee, I am strongly in favor of extending increased aid to the States for the construction of hospitals. I should like to testify in favor of H. R. 3737, introduced by Congressman Bennett of Florida. I understand that H. R. 3737 is identical to S. 614 as it is proposed to be amended by Senators Pepper and Holland.

The purpose of these amendments is to correct an injustice in S. 614 to those lively and progressive communities which were the first to take advantage of the Hill-Burton Act. It is my understanding that approximately 525 projects were approved for construction under the act before January 1, 1949. I feel it would be unfair to penalize these 525 projects by denying to them the increased aid which we propose to extend to projects approved after January 1, 1949. To do this would place a penalty on energy and resourcefulness.

Many of the projects which received early approval were undertaken at great sacrifice on the part of the communities involved and were made possible only because of the courage, hard work, and ingenuity of the citizens. The first large health center to be completed in the United States under provisions of the Hill-Burton Act was constructed in my district. Our health officer tells me that our new Public Health Building was the second project to be approved under the act in the entire country. We know first-hand the complication and difficulties encountered in raising the necessary money and the miracles that can be accomplished by courageous and determined citizens.

Since there are only around 500 projects in danger of being excluded from the proposed program of increased aid for hospital construction—since these represent the real pioneering work of the program, in many cases in the areas of greatest need—I feel that the only fair and proper course is to make the increase retroactive to the beginning of the hospital-construction program. The Hill-Burton Act became effective on August 13, 1946. I agree with Senators Holland and Pepper and Congressman Bennett that the expanded program should be made retroactive to that date.

Statement of Hon. Reid F. Murray of Wisconsin in Favor of H. R. 3737

Mr. Chairman, I am submitting this statement in behalf of H. R. 3737, the hospital and construction amendments of 1949, the enactment of which legislation is necessary for the completion of the 198 projects approved for construction contracts before January 1, 1949, under the provisions of the Federal Hospital Survey and Construction Act, passed by the Seventy-ninth Congress.

In my Seventh Congressional District of Wisconsin, the William Finney Memorial Hospital at Clintonville, Wis., for whch a $254,211 grant was approved before January 1, 1949, will be entitled to only one-third of the construction cost unless H. R. 3737 is enacted. The city of Clintonville, Wis., started their hospital-building program last year and set out to raise the funds through public subscription, a bond issue, or other usual means of raising such funds; and, in view of present conditions and the difficulty in raising additional local funds, it will be necessary for them to obtain further State and Federal assistance. The attached letter from Mr. S. J. Tilleson, clerk of the city of Clintonville, Wis., further substantiates their need for assistance.

I urge that favorable action be taken by your committee on H. R. 3737, and it is my hope that the more liberalized hospital-construction grants provided under the pending bills will be extended.

CLINTONVILLE, WIS., *June 24, 1949.*

Hon. REID F. MURRAY,
Member of Congress, Washington, D. C.

MY DEAR CONGRESSMAN: The city of Clintonville is vitally interested in the passage of House bill 3737 with the Holland-Pepper amendments thereto.

Our city of Clintonville embarked on a new hospital-building program last year, and the hospital is now nearing completion, but so far we have been unable to raise all the necessary funds to complete and equip the new hospital.

We are receiving from Federal and State funds one-third of the cost of this project, but for a city of our size to raise the two-thirds has proved a much bigger job than we had anticipated. With conditions as they are in Clintonville and throughout the country due to the slump, we are in need of further help from the Federal Government; and if this bill (3737) passes with the amendments and becomes law, we will be able to get additional funds to help us finish our hospital and equip it as it should be.

I hope that you will support this bill when it comes up in the House and also the amendments to make it retroactive to 1946.

Very truly yours,

S. J. TILLESON, *City Clerk.*

HOUSE OF REPRESENTATIVES,
Washington, D. C., June 23, 1949.

Hon. PERCY PRIEST,
Chairman, Public Health Subcommittee,
House Interstate and Foreign Commerce Committee,
Washington, D. C.

DEAR MR. CHAIRMAN: I understand that your subcommittee will conduct hearings on H. R. 3737, introduced by Mr. Bennett of Florida, on Wednesday and Thursday, June 29 and 30, and inasmuch as it seems quite probable that my own committee work may prevent my attendance at these hearings, and I have a very vital concern in the provisions of Mr. Bennett's bill, I wish to submit this written statement of interest in the matter for inclusion in the hearings.

The Arkansas State Mental Hospitals, the Hot Springs County Memorial Hospital, and the Drew County Hospital within my congressional district, and for which Federal grants were approved before January 1, 1949, will be denied the benefits of the more liberal hospital-construction grants proposed by House bills 2176, 2567, 3025, and Senate 614, unless provisions similar to those contained in Mr. Bennett's bill above mentioned are adopted. As he has brought out, it would mean that communities which have exercised the greatest courage and initiative in creating a definite hospital program—floating bond issues, preparing plans, and which have placed their hospitals under construction at an early date—would be penalized for having done so. Further, the size and design of many of the hospitals completed or now under construction were not determined by the needs of the community, but rather by the ability of the community to raise two-thirds of the construction cost, and any more liberal grants to those communities would enable them to more nearly meet their minimum community requirements.

I feel very keenly that such discrimination against those projects approved before January 1, 1949, should not be permitted, and I bespeak the most earnest consideration of your subcommittee of legislation to correct such discrimination.

Sincerely yours,

W. F. NORRELL.

Statement of Hon. Thomas A. Jenkins, a Representative in Congress From the State of Ohio

Mr. Chairman and members of the committee, I appear in behalf of H. R. 3737, which is a bill introduced by Congressman Charles E. Bennett of Florida.

My special interest is to encourage legislation that will equalize Government contributions for public hospitals. I have read the brief prepared by Congressmen Bennett, and I approve it most heartily. He points out that there is every reason to include hospitals that were commenced before the first of January 1949. I am especially interested in the hospital at Nelsonville, Ohio, which comes within that category.

The people of Nelsonville and vicinity deserve a great deal of credit for the work they have done in an effort to establish a hospital in that community. They have raised more than $250,000 by private subscription from among their own people. I know there are not many, if any, towns in the United States the size of Nelsonville that could have done as well as its people have done. The Government has already made a grant of about $400,000 for the construction of this hospital and, in addition to the subscriptions made by the people of the community, the Sisters of St. Francis have furnished about $600,000.

Nelsonville has a population of less than 5,000, but it is surrounded by at least a dozen small villages within a radius of 10 miles. The chief industry in the community for many years has been the mining of coal. This is highly hazardous employment, with the result that there are many accidents that need immediate attention. Several years ago I saw only a few miles from Nelsonville the results of a terriffic mine accident in which 80 men were killed, and I saw these men all laid out awaiting the coming of the undertakers and the relatives to claim them. This new hospital at Nelsonville will take care of a large surrounding area in which there is now no hospital. The area will extend into four different counties.

Without the passage of the legislation above referred to, those in charge of this hospital will have great difficulty in furnishing money to equip it. The drive made sometime ago to raise the $250,000 exhausted the resources of the community. Unemployment has also increased greatly in that section, with the result that many people who have contributed before cannot contribute again.

There is complete harmony among the people in that whole section, and they have done the best they can and they naturally feel they should be encouraged. I hope, therefore, that your committee will give careful consideration to the bill introduced by Mr. Bennett; and, if there is any further information the committee might need in reference to the situation at Nelsonville, I shall gladly furnish it.

Statement of Hon. Wesley A. D'Ewart Relative to H. R. 3737 and Similar Bills

Mr. Chairman and members of the committee, with regard to pending legislation to liberalize the Hospital Survey and Construction Act, I wish to express my support of the retroactive principle contained in H. R. 3737 by Mr. Bennett of Florida, one of the measures before your committee.

If it is the intention of Congress to increase Federal participation in the construction of hospitals which qualify under this act, I believe the additional funds provided should go to the communities who have pioneered this work during the past 2 years as well as to those which will build hospitals in the future. It my understanding that the sole difference between Mr. Bennett's bill (H. R. 3737) and the other measures is the fact that all projects would benefit under the Bennett bill, while only those initiated after January 1, 1949, would receive the additional funds contemplated in other measures.

The retroactive principle would be of immense value to the McCone County Hospital at Circle, Mont., which is now under construction. The McCone County Hospital was given a grant of $47,918, and the original proposal was such that the local citizens were able to provide the balance. Costs have risen, however, as new features were found necessary, with the result that the community is unable to meet its full share of the cost of the hospital, and there is serious danger that it may not be completed.

If additional Federal aid is to be provided under this program, and if it is made retroactive to projects approved in 1948, the McCone County project would receive approximately $21,000 in additional Federal funds, which would permit completion of the hospital without difficulty.

I attach for your consideration and for the record a copy of a resolution on this subject by the McCone County commisisoners and a copy of a letter from Mr. F. S. Kalberg, a prominent local citizen.

Four other hospitals in my district have received initial approval but have not yet received grants of funds. These institutions, at Shelby, Malta, Big Timber, and Choteau, Mont., may or may not be affected by the retroactive provision, depending upon interpretation of the law.

My position with regard to this legislation is simply that all hospital projects in all communities should be treated alike, and that no community should, in effect, be penalized because of the ambition and resources that enabled it to get a head start over other cities and towns.

The extra funds which may be required to include all hospitals in this generous new proposal is relatively small when one considers the additional $75,000,000 annual Federal contribution proposed in these measures. In fairness, I hope the committee will include the retroactive provisions in any legislation it recommends.

Thank you.

RESOLUTION OF THE BOARD OF COUNTY COMMISSIONERS OF McCONE COUNTY, MONT.

Whereas S. 614, which proposes to amend the Federal Hospital Survey and Construction Act of the Seventy-ninth Congress, is now being considered by the present Congress; and

Whereas the United States Senators from the State of Florida have jointly proposed amendments to S. 614, which in effect would make the provisions of this bill applicable to all hospital-construction projects for which grants have been approved under the provisions of the present act; and

Whereas the members of this board have carefully studied S. 614, and the proposed amendments; and

Whereas it appears to us that the provisions of S. 614 are in the interests of the Montana hospital-construction program, and that the retroactive provisions of the proposed amendments are of vital interest to the McCone County Hospital now under construction at Circle, Mont., and are necessary to prevent an injustice to McCone County, Mont., for which a grant was approved before January 1, 1949, for the reason that it is impossible to complete the construction of said McCone County Hospital in accordance with the plans and specifications without additional funds which must be derived by personal donations or by an additional grant, and it appears to be impossible to obtain further donations, and the construction of a hospital according to the present plans and specifications is vitally necessary for the welfare of the people of McCone County, Mont.: Now, therefore, be it

Resolved, That the Board of County Commissioners of McCone County, Mont., in regular session assembled, hereby tenders its full approval and support of S. 614, as amended, and be it further

Resolved, That a copy of this resolution be sent to each member of the Montana congressional delegation.

CIRCLE, MONT., *May 24, 1949.*

Hon. WESLEY A. D'EWART,
United States Congressman for Montana,
Washington, D. C.

DEAR MR. D'EWART: First let me tell you how pleased we are over your splendid work in behalf of the appropriation for the N–Bar–N Irrigation project in our county. Our REA hopes to be able to provide the power to operate it.

But now I come to the hospital at Circle. We have received information regarding S. 614, which provides that hospitals in the same class as ours, which are to be built after January 1, 1949, would receive 50 percent Federal assistance in place of the one-third as first provided. This would leave out 198 who have carried the brunt of this fight to provide hospitalization to the little people out in such far-away places as Circle. It seems unfair to us. That is not all. When we first asked for an estimate of costs to erect a ten-bed hospital, it was placed at $93,800. We had bonded for $50,000 and figured we could raise enough more to get Federal assistance to raise the required amount. I was appointed to head the drive for contributions. But then little by little there were new features added until now the total cost is around $145,000. People have been liberal, and we have raised in cash and pledges some $27,000. It is not enough, and some of the pledges may not be paid. We are now building the hospital and are becoming alarmed over the possibility that we may not be able to raise the balance needed.

Now, if this bill could be passed and were made retroactive so as to take in all hospitals both those completed and those like ours, in the midst of construction, then we would receive some $21,000 more, and that would enable us to equip the hospital with necessary modern equipment that we now cannot possibly buy if we do finish the building. It is really serious. As you know, we are 50 miles from the nearest hospital, with not too good roads. Many people are ill, but keep putting it off because it is so far from home and family. I sincerely believe many lives would at least be prolonged if we could get this help to complete this institution.

Please look into this for us and let me know just where it stands. If you feel you can give it your valuable support, it will be most highly appreciated.

With kindest personal regards, I am

Very sincerely yours,

Fred S. Kalberg.

Statement of Robert L. F. Sikes, Congressman, Third District Florida, on H. R. 3737

Mr. Chairman and members of the committee, I appreciate this opportunity to appear before you for the purpose of reporting the progress that we have made in Florida on our hospital construction program, and discussing with you several proposed amendments to the Hill-Burton Act now being considered by this committee.

In Florida we now have grants approved for 17 hospitals and health center projects representing a construction program of approximately $14,000,000.

Of these 17 projects, 1 has been completed and 9 are now under construction representing approximately $11,000,000 in contracts. All of these projects are in A and higher B priority areas.

During the past several weeks I have had an opportunity to study the testimony presented early last month before the Senate subcommittee which heard proposed amendments to our Federal Hospital Survey and Construction Act. During the course of these hearings several competent authorities impressed upon the committee the desirability of increasing the annual contractual obligation authority of the Surgeon General and the desirability of providing funds to make possible research experiments and demonstrations for the purpose of determining the possibilities of coordinating the services of hospitals.

In reviewing a preliminary list of those who were expected to testify before this committee I observed that several authorities who appeared before the Senate subcommittee were also scheduled for testimony before this committee. I presume that their recommendations to this committee will be the same as their recommendations to the Senate committee. I will, therefore, restrict my remarks primarily to two phases of the bills under consideration which I feel have not received the attention which they deserve in relationship to their importance to the continued fair and harmonious development of our program. During the Senate hearing little attention was given to the importance of extending the duration of the act over a significant period of time to allow effective advanced planning.

Under the present act it appears that we will have sufficient funds to entertain applications from only "A" and high "B" priority areas in the State of Florida. There is a real need for additional hospital beds in our low "B" and "C" priority areas; however, hospital groups in these lower priority areas, under the conditions of the present act, cannot plan hospitals or additions of existing hospitals with any degree of certainty. If the act is extended for a period of years we can give our lower priority areas some assurance of financial assistance, which assurance would enable prospective applicants in these areas to start planning now for projects expected to be placed under construction several years from now. May I remind the committee that usually from 1 to 2 years or more pass between the time a community definitely decides to build a hospital until the hospital is placed under construction. But elections must be held, bond issues validated, a site must be selected, financial studies must be made, preliminary plans must be prepared and studied, and second-stage drawings and outline specifications thoroughly analyzed before the architect starts the long and laborious task of preparing detailed working drawings and contract specifications. After the final plans and specifications are thoroughly checked and construction estimates prepared, the architect must then advertise for bids and allow prospecive bidders from 45 to 90 days to study the plans and specifications before bids are received. If, when bids are received, it is found that the cost of the proposed structure is in excess of available funds, the architect must rework his plans and specifications to reduce the cost of the project. Each step requires time.

House bills 3737, 2176, 2567 and 3025 propose to extend the program 4 years. Title III of H. R. 4312 and H. R. 4313 would extend the program to June 30, 1957. The longer extension proposed by H. R. 4315 and H. R. 4313 allows for more advanced planning.

The second point which I believe did not receive the attention its importance deserves in the discussions before the Senate Subcommittee is the determination of the effective date for the increased grant percentage proposed by House bills 3737, 2176, 2567, 3025, and title III of House bills 4312 and 4313.

According to House bills 2176, 2567, and 3025 all grants approved after January 1, 1949, would be for that portion of the project cost equivalent to the State's allotment percentage. The allotment percentage of most States is greater than 33.33. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. As of January 1, 1949, construction grants had been approved for approximately 525 projects throughout the Nation. Of these 525 projects only 188 were under construction and only 10 actually completed as of January 1. According to the provisions of these three bills grants for the 10 completed projects and those 188 projects which received final approval for the letting of contracts before January 1 would remain pegged at one-third of construction cost; and, depending upon the interpretation which may be given by the general counsel of the Public Health Service, the projects which had received preliminary approval before January 1, 1949, but which had not received final approval for the letting of contracts might also be placed in the same category. This would mean that communities which have exercised the greatest courage and initiative in creating a definite hospital program, floating bond issues, preparing plans, and which have placed their hospitals under construction at an early date would be penalized; and those communities which have exercised less courage and initiative and whose hospitals went under construction after January 1 or will not go under construction until some future date would receive grants in excess of one-third of construction costs.

It is felt most important that the increased grant percentage proposed by House bills 2176, 2567, 3025 and others be made retroactive to the beginning of the program in order that all communities building hospitals might share equally in the benefits of the program. If this were an old program, and if many hospitals had been completed under the provisions of the present act, it would be unreasonable to request that the new allotment percentage be made retroactive; however, since the program is so new with only 198 projects actually placed under construction throughout the Nation and only 10 projects completed in the entire United States before January 1, it appears only reasonable that the increased grant percentage be made applicable to all approved projects.

Should the Congress fail to make the proposed increased grant percentage applicable to those 198 projects approved before January 1 it would not only penalize these applicants for their courage and initiative in securing early approval but would also defeat the stated purposes of the program, the purposes being to secure a more even distribution of the hospital throughout the Nation by encouraging and assisting in the construction of "the necessary physical facilities for furnishing adequate hospitals, clinics, and similar services to all their people." This contention is substantiated by an analysis of the 198 projects approved before January 1, the grants for which projects would be pegged at one-third of construction costs by the provisions of H. R. 3176, H. R. 2567, H. R. 3025 and several other bills now being considered.

An analysis of these 198 projects approved for construction contracts before January 1, 1949, reveals the following:

(1) Of these 198 projects, only 10 small projects with grants averaging less than $71,000 each were completed before January 1, 1949.

(2) These 198 projects are distributed through 42 States.

(3) Over 80 percent of these 198 projects were approved during the last 6 months of 1948, and contracts were let when building costs were at a peak.

(4) These 198 projects were predominantly small rural general hospitals.

(5) These 198 projects were predominantly in A and high B priority areas, that is, those areas in greatest need of hospitals.

(6) The applicant's two-thirds of the construction costs of these 198 projects were raised predominantly through the issuance of bonds, revenue certificates, and other types of indebtedness.

(7) Most important of all, the beds provided by these 198 projects approved before January 1, 1949, will provide only approximately one-fourth of the minimum bed needs in these A and high B priority areas, as defined by the State plans of the 42 States in which these early projects are located.

These early applicants who have raised through public subscription, the issuance of bonds, revenue certificates, and other types of indebtedness the two-thirds of the cost of planning, constructing, and equipping these small hospitals have, in most instances, depleted their financial resources for many years to come. The size and design of the hospitals which they are building or have built were not determined by the needs of the community but by the ability of the community to raise two-thirds of construction cost.

If the proposed liberalized grant percentage is not made retroactive, these 198 areas who have strained their financial resources to build small hospitals which meet only a fraction of their admitted minimum hospital needs will be "frozen" with their small inadequate hospitals for many years. Few will be able to raise additional local funds to qualify for a second grant for enlarging their hospitals even under the liberalized grant percentage. However, if the effective date for the more liberal grant percentages is made retroactive these applicants will receive additional funds which may be used for enlarging these small hospitals to more nearly meet their minimum community needs. They would then have in proportion to local funds involved, a hospital of a size and design comparable to those communities whose final applications were approved, or will be approved, after the arbitrary date January 1, 1949.

H. R. 3737 corrects this discrimination against projects approved before January 1 by stating August 13, 1946 (the date on which the present act became law) as the effective date for the more liberal grant percentages. This will allow the projects approved before January 1 to participate in the more liberal grants and, thereby construct nursing wings to these small hospitals in order that they might more nearly meet the minimum hospital needs of the communities involved. These communities would then have in proportion to local funds involved hospitals of a size and design comparable to the communities whose final applications will be approved after January 1.

Mr. Chairman, may I give the committee several examples to show exactly what I mean?

1. One of the projects now completed in Florida is the Suwannee County Hospital located in Live Oak. According to the nationally accepted formula (2½ beds per thousand population served) for minimum hospital needs, a rural area such as is served by the Suwannee County Hospital should have a 70-bed hospital. After several years of careful planning and by straining their financial resources, the people of Suwannee County were able to raise only two-thirds of the cost of building a 36-bed hospital which provides this area with approximately 1.3 beds per thousand population or approximately one-half of the admitted hospital needs of the area. Furthermore, in order to supply two-thirds of the cost of constructing this small hospital it was necessary to delete from the original plans provisions for labor rooms, minor surgery, a nurses' residence and other needed facilities. At present, the Suwannee County Hospital is finding it necessary to rent at a cost of $125 per month a residence to house their nursing and technical staff.

Had the grant for this project been for that proportion of construction costs now proposed by the several House bills now being considered, the people of Suwannee County would have been able to construct a hospital of a more adequate size and design. If H. R. 3737 is enacted, additional funds will be available to construct the much-needed facilities which were deleted from the original plans.

2. *South Florida Crippled Children's Hospital, Coral Gables.*—For the past 8 years the South Florida Children's Hospital Corp. has been raising funds for the construction of a much-needed orthopedic hospital for the children of southeast Florida. When detailed estimates were received late last year for the construction of this hospital, it was evident that the funds of the hospital, plus the matching funds provided under the present act, were insufficient to meet the cost of building and equipping the hospital as planned. As a result, it was necessary to eliminate an entire 22-bed nursing unit intended for the treatment of poliomyelitis. Omission of this nursing unit reduced the capacity from 96

to 74 beds. Should the provisions of H. R. 3737 be enacted, the owners propose to complete the hospital as originally planned including the nursing unit for treatment of poliomyelitis.

3. *Southeast Florida Sanatorium, Lantana, Fla.*—The 1947 Legislature of Florida appropriated $2,500,000 to be used by the State tuberculosis board in matching Federal funds for the construction of two critically needed tuberculosis sanatoria. When bids were received for a 400-bed sanatorium now under construction at Lantana, it became evident that the State tuberculosis board would have only sufficient funds to meet two-thirds of the cost of building and equipping this one sanatorium. This sanatorium, when completed, together with the existing sanatorium at Orlando, will provide less than one-half of the beds needed to care for tubercular patients in Florida.

Should the provisions of H. R. 3737 be enacted, thereby requiring the State tuberculosis board to supply only 42½ percent of the construction costs of this hospital instead of the 66⅔ percent as required by the present act, the board would then have a sufficient balance of unobligated funds in its State appropriation to match Federal funds on the basis of the proposed new grant percentage to construct a new 200-bed sanatorium in west Florida which is the next project on the established construction program of the State tuberculosis board.

4. *American Legion Hospital for Crippled Children, St. Petersburg.*—For over 10 years the American Legion Hospital for Crippled Children, a nonprofit corporation, has been accumulating funds for the purpose of constructing a modern fireproof hospital to replace the present two-story, wood frame, converted residence which they have been operating as a crippled children's hospital for the past 20 years. Because of the nature of the patients served by this hospital, this two-story frame structure has been considered and declared a most serious fire hazard.

When bids were received for the construction of this new hospital, the corporation found that they did not have sufficient funds to defray two-thirds of the cost of constructing and equipping the hospital as planned. As a result, is has been necessary by three series of addenda to the specifications to eliminate facilities both necessary and desirable for the effective operation of a children's hospital to the extent of approximately $70,000 in order that a construction contract might be let. Actual construction has just been started. If the provisions of H. R. 3737 are enacted the facilities which have been deleted from the construction contract could be reinstated and the hospital completed as originally planned.

5. *Florida A. & M. College Hospital and School for Nurses.*—The construction of this project is most important to all Florida hospitals in order that we might have a continuous supply of well-trained Negro nurses for the care of Negro patients. When bids were received for the construction of this hospital and nursing school it was found that sufficient funds were not available to defray two-thirds of the cost of the project. As a result Dr. William Gray, president of A. & M. College for Negroes, representing the faculty and student body, asked the State board of control to approve the issuance of revenue certificates to be retired by an infirmary fee which Dr. Gray proposed be levied against all students at A. & M College for the next 20 years. This infirmary fee, when added to other existing fees, will be a real burden on the students of the A. & M. College. The project was finally approved and placed under construction only a few days before January 1, 1949. According to the provisions of House bills 2176, 2567, and 3025, had this project been approved and placed under construction after January 1, 1949, the issuance of these revenue certificates and the assessment of student fees would not have been necessary. Should the provisions of H. R. 3737 be enacted it will not be necessary to execute the revenue certificates as proposed.

6. *Bay County Hospital, Panama City.*—Panama City is an industrial and resort community the population of which has quadrupled during the past 20 years. Since 1940 the population of this community has more than doubled, primarily as a result of commercial and service activities during the war. It has been served by 3 small hospitals totaling less than 65 beds, 2 of which are converted frame residence buildings. For the past 7 years the people of Bay County have been trying to construct a community hospital. A 100-bed hospital was designed immediately before the war. After the war the cost estimates for this 100-bed hospital had increased to such an extent, it was found impossible to rasie sufficient funds to place the project under construction. New plans were prepared for a 60-bed hospital so designed that two 30-bed wings could be added at a later date. When bids were received on this 60-bed hospital it

was necessary that the Board of County Commissioners obligate over $70,000 of their general county operating funds for the next 3 years in addition to a 20-year bond issue in order to meet two-thirds of construction costs.

The population of this hospital service area is over 50,000 persons. To meet the minimum general hospital requirements of the area would require over 200 general hospital beds. Because two of the small hospitals have recently been closed this community has, since the completion of the community hospital, only approximately two beds per thousand population or approximately one-half of their minimum hospital needs.

If H. R. 3737 is enacted a 30-bed wing and a most necessary nurses' residence can be added immediately. This community would then have in proportion to local funds involved a hospital of a size and design comparable to those communities whose applications for grant assistance are approved after January 1, 1949.

Mr. Chairman, I hope that a study of these specific examples will impress the committee on importance of making the new grant percentages applicable to all projects in order that all communities building hospitals under this program might share equally in the benefits of the program.

Florida is not the only State concerned by the effective date for the proposed new grant percentages. Forty-two States had projects approved and under construction before January 1, 1949, representing approved grants of over $30,000,000. The Public Health Service has estimated that it would require approximately $23,000,000 to adjust all grants approved before January 1, 1949, to an amount equivalent to the State's respective allotment percentage. However, less than $23,000,000 would be required should the Congress choose to limit grants to a miximum of two-thirds of project costs.

Mr. Chairman, I earnestly recommend to the committee the provisions of H. R. 3737.

Thank you, Mr. Chairman.

STATEMENT FOR HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE IN SUPPORT OF H. R. 4215, SUBMITTEE BY HON. CHARLES B. DEANE

Mr. Chairman and gentlemen of the committee, on April 12, 1949, I introduced in the House H. R. 4215, a bill to amend title VI of the Public Health Service Act to provide additional Federal aid in the construction of hospitals, to provide Federal aid in the maintenance and operation of hospitals, and for other purposes. This bill as the title indicates would provide for increased hospital construction and an expansion of a program now being administered by the United States Public Health Service. That program has already been started in a modest way, and something has been accomplished, but with the passage of H R. 4215 we could achieve a really adequate hospital construction program and much-needed results in terms of additional medical personnel who could cope with our national health problems.

Let us look at the extent of our national health problems at this time. They have been analyzed in a document entitled "The Nation's Tealth: a Ten Year Program." This report by the Federal Security Administrator to the President (September 1948) contains statistics which have been challenged, by those who oppose the compulsory insurance feature of the administration's health plan but in the absence of other comparable studies, I think we must accept the basic data of this report which was made by a reliable Government agency.

Although the health record of the people has been improved during the last generation, there are still losses arising from sickness, disability, and death, much of which could be prevented if we had adequate health service for the entire population.

Our health manpower—that is, doctors, dentists, nurses, and related health personnel—is insufficient in numbers and is poorly distributed throughout the country. We have only about 80 percent as many doctors as we need and if we do not take action to train additional doctors we shall still have only 80 percent of what we need for our increased population in 1960. This means that by 1960 we shall be short 42,000 physicians. The distribution of the doctors we have at present is very uneven. For example, there is a doctor for every 500 persons in New York State, but in Mississippi there is only 1 doctor for every 1,500 people. North Carolina has a doctor for every 1,300 people. In California there is 1 dentist for every 1,300 people, but in North Carolina 4,500 people must share 1 dentist. Connecticut has a nurse for every 200 people but North Carolina has only 1 nurse for 1,060 persons. Some States have counties where there are no physicians at all.

Now when we come to consider how we can attain the goal of adequate medical manpower we come up against two facts: (1) it takes time to train doctors, dentists, and nurses and (2) we have a very small number of qualified schools and colleges conducting this training. It takes from 7 to 10 years for a medical student to become a doctor, and it takes from 3 to 5 years for a nurse to complete her training. Our 70 medical schools have an average enrollment of 335 students, with an average graduation of 80 toward a national total of 5,600 doctors. Six new schools are now being organized, but even so we can hope to have by 1960 only 212,000 active doctors.

It has been estimated that we should have 254,000 doctors by 1960, which fact would mean that we should have to double our medical education capacity. This, obviously, would be most difficult to do since we do not have enough teachers to double the number of medical students.

Meanwhile, our medical schools, far from being in a position to expand, are hardly able to keep up with their present enrollments. It would seem that medical schools cannot be kept up or expanded unless public funds are now made available to them.

The problem of the shortage of nurses is not merely one of teaching as shown by the fact that there are not enough enrollments in many cases. The entire training system needs revision so that the profession will be more attractive to young women.

In addition to the lack of medical personnel, the financial straits of the medical schools, and the uneven distribution of the professional people we do have in the health field, there is the problem of the cost of medical care. The report on the Nation's health estimates that only 20 percent of the people are able to afford all the care that they need, while about half (those with $3,000 a year or less) find it difficult to pay for even routine services. If the people do not have the purchasing power, naturally this is a factor in limiting the number of health personnel.

This, then, is the health problem in its most important aspects, and it has given rise, as do all problems, to the introduction in Congress of a number of bills designed to bring about a solution to one or all of the difficulties involved.

In meeting our health problems, it would be wise to do first things first, and then as our experience grows, and we are ready, we can take another step toward the direction of the goal on which everyone seems agreed: Adequate health facilities for everybody in the United States.

I am a practical man, and I would like to do something practical about the health problems in the United States. I have studied all the bills which have been introduced in this session of Congress on this subject, and I have found that there are some points on which there is almost unanimous agreement as to the facts and the course of action to be taken. This is particularly true of hospital construction, aid to medical schools, and a scholarship-and-loan program for students in the health fields. All of these points are comprehensively covered in the provisions of H. R. 4215, upon which I now urge your committee to take favorable action.

We must tackle our health problems at those points where we can best take hold at first. After all, we have to operate in the realm of practical results, and I think we should select the parts in the over-all health picture on which there is general agreement so that we can get started somewhere immediately. That is what I have had in mind in introducing H. R. 4215. I am trying in this bill to get at the common denominator upon which we have agreement. Accordingly, I sincerely urge that your committee favorably report this bill to the floor of the House in time for use to secure its adoption at this session of Congress.

Statement of Hon. Francis Case, of South Dakota, on H. R. 3737

Mr. Chairman, I wish to add my earnest endorsement of H. R. 3737, the bill which proposes to eliminate discrimination against the hospitals which first qualified for aid under the Federal hospital-aid program.

The problem is strikingly presented in South Dakota. One community and one community alone is affected: that of Winner, where the Rosebud Community Hospital is being built. Rosebud Hospital at Winner alone was the only hospital project in the State receiving approval prior to January 1, 1949.

Should the enterprise and sacrifice of the people which met the qualifications first be penalized?

This particular hospital is being built in an area where the people went through very severe suffering during the drought period of the thirties. They have been coming back in recent year. No large donors made possible the building or starting of the Rosebud Hospital. Only the modest gifts of a great percentage of the people made it possible.

Without the Federal aid as an encouragement, it is doubtful if the hospital program would have gotten very far. Certainly it would not have been far enough along to have qualified prior to January 1, 1949. Will the very fact that the Federal hospital program proved enough incentive to get the Winner Hospital Association to redouble its efforts be used against it, to penalize it by denying as large a grant as would have come if it had been a little slower, just a few weeks slower? That is inconceivable.

If the Federal hospital program is to be made more generous, so that 54 percent of the construction cost will be provided by the Federal Government as against the original 33⅓ percent, this new program should be made retroactive, as proposed in H. R. 3737.

STATEMENT BY CHESTER E. MERROW, M. C., ON H. R. 1721

Mr. Chairman, last year on June 7, 1948, I introduced H. R. 6824, a bill proposed to amend the Public Health Service Act approved August 13, 1946. On January 24, 1949, I introduced H. R. 1721 (the same as H. R. 6824), which is as follows:

"*Be it enacted by the Senate and House of Representatives of the United States of America, in Congress assembled,* That section 625 of the Public Health Service Act, as amended, is hereby amended by adding at the end thereof the following new subsection:

" '(f) In the case of any hospital on which construction has been commenced after May 1, 1946, and before July 1, 1948, which is approved by the Surgeon General as a project with respect to that part of the construction of such hospital to be undertaken after the date of such approval, the Surgeon General, with the concurrence of the State agency, is authorized to waive compliance with any requirement of subsection (a), with respect to the construction commenced on such hospital prior to the date of such approval, if he finds that the purpose of such requirement has been accomplished, and to certify funds sufficient to pay 33⅓ per centum of the cost of such prior construction, if funds are available for such purpose from the allotment to the State.'

"SEC. 2. Section 631 (i) of the Public Health Service Act, as amended, is hereby amended to read as follows:

" '(i) The term "cost of construction" means the amount found by the Surgeon General to be necessary for the construction of a project, including, in the case of any hospital on which construction has been commenced after May 1, 1946, and prior to July 1, 1948, and which is approved as a project with respect to that part of the construction of such hospital to be undertaken after the date of such approval, costs incurred prior to the date of such approval.' "

The purpose of this bill is to give assistance to the Laconia Hospital in Laconia, N. H. Although H. R. 1721 covers the Laconia Hospital in particular, its application would be general.

The contract for the Laconia Hospital was signed with the Trumbull Associates of Hanover, N. H., on May 21, 1946. Construction on the nurses' building began in June 1946, and on the main hospital building in November 1946. The date May 1 is used in my bill simply because it is the first of the month in which the contract was let for the Laconia Hospital. The facts concerning the Laconia Hospital are as follows:

In 1944, the Laconia Hospital had 89 adult beds and 25 bassinets. The number of patients receiving care represented 86 percent of the hospital's capacity.

Plans for a hospital of 128 beds and 35 bassinets and an enlarged nurses' home were approved by the trustees in 1945.

A campaign for this building program was oversubscribed in 1945, the total being over $400,000. The average number of patients went to over 90 percent capacity in 1945 and 105 percent in 1946, although for most of the time only emergency cases were accepted.

Because of the greatly increased demand for hospital care, plans were changed for a larger hospital of 138 adult beds and 36 bassinets. Plans for the enlarged nurses' home were changed to a new building, including a nurses' school and residence.

Because of increased costs and enlarged program, a second campaign for funds was conducted in 1947 for $200,000. In addition to the $400,000 in the first campaign and the $200.000 in the second campaign, $200,000 was borrowed, making a total of $800,000 raised.

The nurses' building is complete at a cost of about $230,000, and a large increase in enrollment in the nursing school proves the wisdom of this planning.

Three floors of the addition of the hospital are complete and occupied. However, to obtain maximum benefits from additional beds and integration of services, it is necessary that the hospital be completed as planned. It is estimated that the additional cost will be $277,000.

By the adoption of the amendment I have suggested, the allocation of Federal funds would be permitted to projects which have been started and which cannot be completed due to insufficiency of local funds. In each instance, the State approving agency and the Surgeon General must give approval to the project.

My amendment would provide Federal assistance to all hospitals so approved on which construction was begun after May 1, 1946.

When the first drive for funds for Laconia Hospital started in 1944, it seemed probable that Federal assistance would be available in 1946 or shortly thereafter.

Laconia enjoys No. 2 priority in the State of New Hampshire under the hospital plan that has been approved for the State.

The trusteees of Laconia Hospital are anxious to get credit if possible for funds which have already been spent. They have already raised $600,000 and borrowed $200,000. They feel that they should get Federal assistance on the basis of the $800,000 they have already raised.

Mr. PRIEST. It will be necessary for the committee to adjourn at this time.

We will stand adjourned until 10 o'clock tomorrow morning.

(Thereupon, at 11 a. m., the committee adjourned to reconvene at 10 a. m. Thursday, June 30, 1949.)

NATIONAL HEALTH PLAN

THURSDAY, JUNE 30, 1949

House of Representatives,
Subcommittee of the Commitee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee) presiding.

Mr. Priest. The committee will come to order.

We are continuing hearings today on various bills proposing amendments to the Hospital Construction Act.

Without objection, at this point in the record, a statement from our colleague, Mr. Miles, of New Mexico, will be included; also a statement of our colleague, the gentleman from Florida, Mr. Smathers; also a statement of the gentleman from South Carolina, Mr. Rivers.

(The statements referred to are as follows:)

Statement of Congressman John E. Miles

Mr. Chairman and members of the committee, I appreciate this opportunity to make a statement in behalf of H. R. 3737.

Mr. Bennett's bill and others before you propose to extend the authority for appropriations, and to extend the effective time for carrying out the Hospital and Survey Construction Act, which has been of such great benefit to every State in the Union during the short time the program has been in effect.

Although all of the several measures before you are admirable in that they propose to extend the duration of the act and increase the authority for annual expenditures and to provide a more liberal grant to the State, I believe that any amendment that is made should follow the lines of the bill which Mr. Bennett has introduced. H. R. 3737, though similar in most respects to the other bills liberalizing and extending the Hospital Construction Act, proposes to extend those liberal provisions to the grants which have already been made under the act.

In my State of New Mexico there have been four grants approved for hospital construction which will be denied the more liberal benefits proposed unless the retroactive provisions of Mr. Bennett's bill are included in the measure amending the act. These grants are:

The Gerald Champion Memorial Hospital at Alamogordo, for which a $78,879 grant was approved.

The Dona Ana City-County Hospital at Los Cruces, for which a $250,000 grant was approved.

The Lea County Community Hospital at Hobbs, for which a $99,999 grant was approved.

The Tucumcari General Hospital at Tucumcari, for which a $15,000 grant was approved.

In fairness to those States and communities which have been fortunate enough to have had early approval of their hospital projects, any amendment to the Hospital Construction Act should be made applicable to grants made prior to January 1, 1949, as provided in Mr. Bennett's bill.

STATEMENT OF HON. GEORGE SMATHERS

Mr. Chairman, it is my desire to place on record my wholehearted endorsement of H. R. 3737, which was introduced by my able colleague, Representative Charles Bennett, of Jacksonville, Fla.

There have been several bills introduced in the House which would amend the Hospital Survey and Construction Act of the Seventy-ninth Congress by increasing the contractual obligation authority of the Surgeon General for hospital construction grants from the presently approved $75,000,000 annually to $150,000,000 annually, extending the duration of the act for 4 years and making the grants in each State equivalent to the State's allotment percentage for all projects approved on or after January 1, 1949, in lieu of the presently required grant percentage of one-third of the project cost. Bills introduced in the House on these points are similar to S. 614 in the Senate.

H. R. 3737 would accomplish all of the foregoing, and, in addition, would make retroactive to August 13, 1946, the provision changing the grant for each project to the equivalent of the State's allotment percentage.

Under the existing program every hospital project which had been commenced has received a Federal grant of one-third the cost, whereas if S. 614 and similar legislation in the House should become law, those projects which are approved after January 1, 1949, will receive a Federal grant equivalent to the State's allotment percentage. In most instances the State's allotment percentage exceeds 33⅓ percent. In the State of Florida, for example, it is 57 percent.

As of January 1 of this year approximately 525 projects had been approved throughout the Nation, of which only 188 were under construction and only 10 had actually been completed. If Senate bill 614 and comparable House bills were to be enacted, the 10 completed projects and the 188 under construction would only be entitled to a Federal grant of one-third of construction costs. It is possible that it may be construed that those not under construction, but approved prior to January 1, 1949, would also be entitled to only one-third of construction costs. This would mean that the communities which had first undertaken the construction of hospitals under the existing program would be penalized in that their Federal grant would be less than the grants to be made after January 1, 1949.

Since this is a relatively new program, with only 10 projects completed, the retroactive feature does not reach far into the past but merely equalizes the grants which will be given to those projects already approved and under construction with those projects which will be approved and construction started in the future.

This retroactive feature of H. R. 3737 will aid projects distributed through 42 States of the Nation. I know that in my own State there are 16 projects which would be assisted by this retroactive feature.

In my own district the South Florida Children's Hospital Corp. has for some 8 years been raising funds for the construction of a much-needed orthopedic hospital for the children of southeast Florida. As the sponsors of this hospital showed great courage in commencing construction prior to January 1, 1949, the Federal grant will only be one-third of the total cost. However, because of insufficient funds, it was necessary to eliminate from the original plans an entire 22-bed nursing unit intended for the treatment of poliomyelitis. Omission of this nursing unit reduced the capacity from 96 to 47 beds. Should H. R. 3737 be enacted, it is my understanding that the retroactive feature of the bill would permit the builders of this hospital to complete the hospial as originally planned, include the unit for the treatment of poliomyelitis.

It is difficult to conceive of legislation which could be designed to accomplish more for the welfare of the Nation. Most of us are in accord that this is the hour for economy, but money spent for better health is not synonymous with waste and pennies saved by failing to build needed hospital facilities would be the acme of false economy.

STATEMENT OF CONGRESSMAN L. MENDEL RIVERS IN BEHALF OF FEDERAL AID FOR HOSPITAL CONSTRUCTION PROJECTS

Mr. Chairman, I consider it a privilege to appear before this committee in behalf of legislation to protect the grants already made to certain hospital construction projects and to provide for more liberal benefits to those communities in dire need of these facilities. It is my understanding that a bill, H. R. 3737, now pending before this committee, contains the necessary provisions to carry out the foregoing program. While I am interested in the program as a whole, I am specifically interested in protecting and liberalizing a grant to the Berkeley County Hospital, Moncks Corner, S. C., which is included in this program.

I am hopeful and have every reason to believe that this Committee will act favorably to help these worthy projects.

Mr. Priest. At this point, in the record, will be included the reports of the Federal Security Agency, the Veterans' Administration, and the Interior Department.

(The reports above referred to are as follows:)

Federal Security Agency,
Washington, April 15, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Chairman: This letter is in response to your request of January 12, 1949, for a report on H. R. 323, a bill to amend section 1 of the act entitled "An Act to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals" (Public Law 830, 80th Cong.)

This bill would amend section 1 of Public Law 830 so as to provide a minimum allotment of $250,000 to each State for the construction of hospitals under section 624 of the Public Health Service Act.

The following table shows the States which would receive increased allotments under the provisions of bill H. R. 323.

State	Allotment for fiscal years—	
	1949 (actual)	1950 (tentative)
Alaska	$100,000	$100,000
Delaware	100,000	100,000
Montana	224,136	173,112
Nevada	100,000	100,000
North Dakota	[1] (287,847)	228,047
Vermont	227,131	217,719
Wyoming	146,879	118,776

[1] Allotment for 1949 exceeds the proposed minimum allotment.

We recommend that the minimum allotment be increased since on the basis of current construction costs, the present minimum Federal allotment of $100,000 is insufficient to permit the payment of the Federal share of the cost of constructing the average size hospital project approved under the program up to this time. Raising the minimum allotment to $250,000 would permit the construction of a hospital with a number of beds equal to or greater than that of the average size hospital project.

Section 2 of Public Law 830 authorizes such additional appropriations as may be necessary to provide the increased minimum allotments under section 1. The additional amount which would be required if H. R. 323 were enacted would be $612,346 per annum.

A technical consideration should be called to your attention. Since the bill is an amendment to Public Law 830, Eightieth Congress, rather than to the Public Health Service Act, it might be interpreted as being effective retroactively with respect to allotments which have already been made for fiscal years 1948 and 1949. See opinion of the Comptroller General, dated August 24, 1948, with respect to Public Law 830. Such a result would create administrative difficulties and would operate to reduce the allotments of the States not affected by the provisions of the present bill in order to raise the allotments of those States which would be affected. To avoid these difficulties, it is suggested that the bill be amended to provide specifically that it shall not be effective with respect to allotments for fiscal years prior to the year ending June 30, 1950.

We would therefore recommend that, as so amended, the bill be enacted by the Congress.

The Bureau of the Budget advises that there is no objection to the submission of this report to your committee.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, April 14, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of January 15, 1949, for a report on H. R. 991, a bill to amend the Public Health Service Act to provide assistance for the construction of hospitals furnishing domiciliary care.

Section 631 (e) of Public Law 725, Seventy-ninth Congress, provides that "the term 'hospital' includes public health centers and general, tuberculosis, mental, chronic disease, and other types of hospitals, and related facilities, such as laboratories, out-patient departments, nurses' home and training facilities, and central service facilities operated in connection with hospitals, but does not include any hospital furnishing primarily domiciliary care;". In this connection, it should be noted that nowhere in Public Law 725 or in the regulations is "domiciliary care" defined. However, section 6, title 2, chapter 4, part 24–1, Grants-in-Aid Manual, states in part that "whether or not a hospital is one which furnished primarily domiciliary care is a matter of determination predicated not on the diagnosis of patients under care or any classification thereof, but by the type of care extended * * *."

In considering H. R. 991, our comments must be directed toward the intended definition of the term "domiciliary care." As Public Law 725 and the regulations thereto are now being administered, projects for the treatment of specific disease entities are considered to be eligible under the program. This would include, for example, hospitals for spastics, children's orthopedic hospitals, facilities for the treatment of cardiac patients, as well as other hospitals providing similar specialized types of care. Domiciliary care would be exemplified by the types of service provided in homes for the aged, rest homes, and such other facilities which house patients without a specific disease entity which responds to medical treatment.

It is believed that the present act is broad enough to cover any type of institution which could reasonably be construed as providing medical care for patients. Should the restriction on domiciliary facilities be removed, all types of institutions such as almshouses, nursing homes, homes for the aged, etc., would apparently be eligible for assistance. Not only would this tend to perpetuate an undesirable type of institution, but it might become a serious handicap to the basic objectives of the Federal act. If it is the purpose of H. R. 991 to utilize funds under Public Law 725, Seventy-ninth Congress, to provide facilities for this type of patient, the Agency must recommend that the bill not be enacted by the Congress.

The Bureau of the Budget advises that there is no objection to the submission of this report to your committee.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, April 4, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your requests of February 15 and March 1, 1949, for reports on H. R. 1721, a bill to amend the Public Health Service Act to authorize the payment of prior construction costs of certain hospitals approved as projects under such act, and H. R. 3070, a bill to amend the Hospital Survey and Construction Act.

These bills would amend section 625 (a) of the Public Health Service Act (as amended by the Hospital Survey and Construction Act, 60 Stat. 1040) relating to applications for hospital-construction grants, so as to permit the Surgeon General to waive compliance with any of the requirements of the subsection if he finds its purpose has been achieved. They would also amend the definition of "cost of construction" in section 631 (i) to permit Federal participation on a retroactive basis in the cost of approved projects. H. R. 3070 would apply in the case of projects on which construction began after August 13, 1946 (the effective date of the act), but before the State plan for hospital construction was approved by the Surgeon General. H. R. 1721 would apply in the case of projects on which construction began after May 1, 1946, and before July 1, 1948.

It is our understanding that the purpose of the bills is to permit Federal aid in the building of hospitals whose sponsors, anticipating Federal aid under the Hospital Survey and Construction Act, began construction before State surveys and State plans required by the act could be completed, and in the case of H. R. 1721, before passage of the act. As you know, the act requires the approval by the Surgeon General of a State plan of hospital construction and a designation by the State of a single State agency to administer the plan before an application for Federal assistance can be filed. Such applications must be approved by the State agency before they can be considered for approval by the Surgeon General. A few communities which were anxious to build hospitals did not wait for passage of the act or approval of the State plan before starting construction, and of these some undoubtedly sincerely believed that Federal assistance under the act would be made available.

Sponsors who thus began construction may have done so in a way which would not, in any case, have met some of the requirements of the act and regulations promulgated thereunder. For example, they may have begun work under a cost-plus construction contract, or may not have paid prevailing wages. The former is not permissible under section 53.77 (c) of the Surgeon General's Regulations under the act and payment of prevailing wage rates is required by the act. Their early start meant that at the time they actually filed their applications some of the construction of the project had already been completed. While the Surgeon General has approved project applications for the completion of facilities, Federal participation in the cost of such projects has been limited to the cost of work not completed at the time of the application. As we read the act, retroactive payments would be contrary to the intent of Congress as expressed in the act. Accordingly, the cost of work in place at the time when application is made has been excluded from costs eligible for Federal participation. For these reasons, a number of such applicants found themselves partially or wholly unable to obtain the Federal funds they had anticipated. The bills would permit waiver of noncompliance with conditions such as the lump-sum (fixed-price) contract and the payment of prevailing wage rates and would allow retroactive payment for construction completed at the time of the filing of the application.

This Agency is sympathetic to applicants who, in a sense, are being penalized for initiative in commencing hospitals without waiting for Federal assistance. However, it would be almost impossible to select the few cases falling within the special class for whom an exception to established rules would be justified. The bills would accord this special treatment to all applications for projects begun within a certain period of time, irrespective of whether there is a real need of or justification for the Federal aid. It should be borne in mind that the 5-year program contemplated under the present act—including Federal, State, and local funds—will meet approximately 15 percent of the needs for additional hospital facilities in this country. Under these circumstances, the importance of using these funds to stimulate the construction of new facilities is clear. We believe that retroactive payment for completed construction will jeopardize the objectives of this limited program.

It should be pointed out at this time that even as to applicants falling within the purpose of the bills, it is extremely doubtful whether the proposed amendments would be of material assistance. All States and Territories, with the exception of Nevada, now have approved State plans and most of them have formulated their project-construction schedules for the fiscal year 1948 and 1949. Applicants contemplated in these bills have not been included in these schedules except for participation in the uncompleted portions of their facilities.

Therefore, granting additional funds to them would be impossible except at the expense of other facilities for which funds have been already allocated.

The Agency therefore recommends that the bills not be enacted by the Congress.

The Bureau of the Budget advises that the enactment of this legislation would not be in accord with the program of the President.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, May 20, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your requests for reports on H. R. 2176, H. R. 2567, H. R. 3025, H. R. 3737, ad H. R. 3515, all of which are bills to amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act) to extend its duration and provide greater financial assistance in the construction of hospitals, and for other purposes.

These bills would make a number of substantive changes in title VI of the Public Health Service Act. Allotments to States for hospital construction are extended through 1955, an increase of 4 years over the existing law. The authorization for appropriation is increased from $75,000,000 to $150,000,000 per annum, beginning with the fiscal year 1949; this has the effect of automatically doubling allotments to almost all States with approved plans. The amount of Federal participation in individual projects is changed from a flat 33⅓ percent in all cases to the allotment percentage of the State in which the project is to be built, which varies from 33⅓ percent to 75 percent. A new position is added to section 632 (a) designed to induce the States to make available a minimum amount for administration of their State plans. A new section 636 is added authorizing the Surgeon General to conduct research, demonstrations, and experiments and to make grants for projects for conduct of experiments and demonstrations relating to the effective development, utilization, and coordination of hospital services, facilities, and resources.

H. R. 3737 and H. R. 3515 differ from the other bills in two respects: (1) they would require the States to provide for administration of the State plan $15,000 or 1 percent of funds proposed to be expended during a given year, whichever is the higher, as opposed to $15,000 or 2 percent provided for in the other bills, and (2) they would make the effective date of the increased Federal aid retroactive to August 13, 1946, as opposed to January 1, 1949.

This agency is in favor of the objectives of the bills. With respect to the specific provisions, we have the following comments:

1. We are heartily in accord with the provisions in the bills increasing the annual amount of Federal authorization of appropriation from $75,000,000 to $150,000,000 per annum, beginning with the fiscal year 1949, and extending the duration of the construction program through June 30, 1955. State plans for hospital construction, based on studies of the need for additional hospital facilities in the several States, indicate that approximately 900,000 more hospital beds must be built before the country's minimum needs can be met. The law in its present form contemplates a program which over the 5-year period now scheduled would meet less than 15 percent of these needs. We believe, therefore, that expansion of the program is imperative if the basic purpose of the act, provision of facilities necessary for furnishing adequate hospital services to the people of this country, is to be carried out.

This view is shared by the State officials administering the program in the several States, as reflected in a resolution of the State and Territorial Health Officers Association at its annual meeting in November 1948. The State officials were particularly anxious that the program be extended in duration so that they might be enabled to plan their programs for some time in the future with confidence. The Federal Hospital Council, which Congress has designated as the body to advise the Surgeon General on his administration of the program, also endorsed similar amendments at its meeting on December 17, 1948. Finally, future expansion of the program was anticipated by the Senate Committee on Education and Labor in its report on S. 191 in the Seventy-ninth Congress, which ultimately became title VI of the Public Health Service Act. The committee stated:

"It is pointed out that the Federal appropriations for construction authorized in this bill represent approximately 20 percent of the total costs of the hospital and public health facilities estimated by the Surgeon General to be needed. As State surveys are completed and State construction programs approved, it may be necessary for Congress to increase the amount of Federal assistance for construction, either by increasing the authorization ceilings or by extending the time period during which Federal funds may be appropriated for this purpose, or through both methods."

The foregoing, together with the widespread popular acceptance which the program has received, would, in our judgment, justify expansion of the program even if Federal participation in individual projects were held at the present flat 33⅓ percent. If this participation is to be substantially increased as proposed elsewhere in the bills—a principle with which this agency also agrees—increase in allotments and duration of the program will be necessary in order to coordinate the amount of Federal authorization for appropriation with the percentage of Federal participation and thus avoid a considerable cut-back in the number of projects which may be assisted under the act. We believe the $150,000,000, proposed in the bills, will accomplish this result.

2. Turning now to the proposed change in the amount of Federal participation in individual projects, this Agency agrees that an increase in the rate of Federal participation is desirable. Under the law in its present form, State and local resources must provide two-thirds of the funds for construction of hospitals aided under the program, as well as all maintenance and operation funds. A large number of poorer communities are unable to raise so large a non-Federal share and therefore are unable to avail themselves of the assistance provided under the act. Since these communities are the very ones the act was primarily designed to help, it follows that some increase in the Federal share is necessary if the purpose of the act is not, to some extent, to be defeated. We also agree that the increase should not be in the form of a flat general raising of the Federal share equal for all projects but should vary with the need shown in particular States. For these reasons we believe that the provisions proposed represent a considerable improvement over the existing law in this respect.

In at least two respects, however, we feel improvements could be made in the approach adopted in these bills. We believe that they are deficient (i) in failing to permit variations in the rate of Federal participation, based on need, as between different projects in the same State, and (ii) in imposing rates on the States on the basis of an arbitrary formula written into the statute instead of allowing a more flexible approach on the basis of need shown. With respect to both points it would appear that the bills would be improved by vesting more discretion in State agencies to fix the amount of Federal participation according to the needs of individual States and individual projects. These points are developed at greater length below.

(i) As now drawn, the bills would make it mandatory that all projects in a State receive the same proportion of Federal participation. This does not allow for variations in economic resources and consequent need of Federal aid between different communities in the same State. Irrespective of the relative wealth of any given State, there are some communities which can afford to construct hospitals with less Federal aid than other poorer communities within the State. In a few States such variations are compensated by State aid which is adjusted to the economic status of individual communities. In the great majority of States, however, this is not true and imposition of a uniform rate of Federal aid has the effect of distributing the economic burden unequally over the State. States should, we think, be permitted and encouraged to provide in their plans for variations in the rates of Federal participation as between projects on the basis of relative need. However, such variations should not be made mandatory on the States but should be adopted only if the State agency, on the basis of the conditions peculiar to its State, believes that its hospital construction program would be best served thereby.

(ii) Even where it is considered desirable to have a uniform rate of Federal participation, we believe that, within reasonable limits, this uniform rate should be prescribed by the State. In its present form the bill leaves the State no discretion in this regard but fixes the Federal rate of participation at the State's allotment percentage. While this has the generally desirable result of providing a higher rate of Federal participation in the low-income States, we think it is not appropriate for all States. For example, where States have their own grant-in-aid programs in operation, the amount of funds which local communities must raise to supplement Federal grants will be substantially reduced.

In such a case, a State, rather than increasing the proportion of Federal aid, may prefer to retain the Federal contribution at a lower level in order that the benefits of the total Federal allotment to the State, supplemented by State assistance, may be spread out over a larger number of projects. We believe that a State should be free to adopt this course.

Conditions on the basis of which such determinations will be made are peculiarly within the knowledge of the State agencies administering the programs for particlar States. It is, moreover, consistent with the basic scheme of the act to give responsibility for such determinations to the various State agencies, to be exercised within the limits of general principles laid down by the Federal Government.

For the foregoing reasons it is recommended that State agencies be given discretion under the act to determine (1) whether the Federal share should be uniform for all projects in the State or should be varied within the State according to need, and (2) within reasonable limits the amount of such Federal share if the same rate for all projects within the State is adopted.

3. Section 4 of H. R. 2176, H. R. 2567, and H. R. 3025 would authorize the Surgeon General to withhold certification of construction payments to any State on a finding that State funds provided for direct administration of the plan are less than $15,000 or 2 percent of the total funds proposed to be expended during the year under the plan, whichever is the higher. The purpose of this amendment is evidently to require States to make possible the development of adequate staffs. This Agency recognizes that the primary role which State agencies have for administration of the program cannot be carried out successfully without sufficient trained personnel. We have serious doubts, however, whether the method proposed in the bills to assure the availability of such personnel will be effective. The sanction provided, application of which appears to rest in the discretion of the Suregon General, is so drastic that if applied it could stop future participation in the program in the State involved. Furthermore, it is almost impossible as a practical matter to devise a satisfactory formula which will indicate with any precision the amount of money which each State should appropriate for administering the program. There is great danger that either the figure will be set so high that States cannot meet it or that a lower figure will be accepted as a ceiling by State legislatures and will not provide any effective stimulus for adequate State appropriation.

If this provision in the bill is retained, we believe the formula should be revised. In its present form it would require disproportionately high appropriations by some States which have large allotments. For example, Pennsylvania would be required to make available well over $300,000 annually for administration. Under the proposal set out in H. R. 3737 and H. R. 3515 the 2 percent would be reduced to 1 percent. While this represents an improvement in one feature, it leaves the fundamental objections which have been outlined above still present. We believe that a formula diminishing progressively after the amount necessary for a minimal staff, while still unsatisfactory, would be more equitable. It may also be necessary to postpone the provision's effective date 2 years, since the legislatures in many States will have adjourned until 1951 before the bill can become law.

The State and Territorial Health Officers Association in its last two annual meetings adopted a resolution favoring Federal grants for State administrative expenses. We believe the importance of securing qualified State personnel is sufficient to warrant expenditure of Federal funds for this purpose to supplement State expenditures on a matching basis. Such a grant would require a comparatively small outlay of Federal funds in terms of the total amounts involved in the program, and would be of great assistance in helping each State to acquire at least a minimal staff.

If the Congress, however, is unwilling to adopt the proposal outlined in the foregoing paragraph, we recommend that the act not be amended in this respect. In any case, we believe that section 4 of the bills should not be adopted.

4. The provision in the bills for research, experiments, and demonstrations on effective utilization and coordination of hospital facilities would be a highly desirable addition to the act. Such activities are an indispensable concomitant of the construction phases of the program if the basic objective of the act, provision of adequate hospital services to the people of this country, is to be realized.

Lack of coordination between hospitals is a serious defect in our present hospital system. In many respects smaller hospitals, especially in rural communities, have neither the equipment nor the personnel to provide many of the services available in larger institutions. Since it is impracticable to make each individual hospital a completely independent unit capable of furnishing all types of services, the logical remedy for the problem is to develop an integrated system of hospitals in which the resources of each are made available, as far as possible, for the benefit of all. This approach has been tried with great success in several localities over the country. Enactment of this section in the bills would enable the Public Health Service to make grants to regional coordinated hospital systems which would promote the development of this desirable practice by affording a model to interested groups.

Although the people of America spend nearly $4,000,000,000 annually for hospitalization, the amount spent for research and study of factors contributing to better hospital services is negligible. There is great need for thorough study of such subjects as hospital finances, personnel, dietary services, medical records, building design and construction, and many others. We believe that such study will make for better use of hospitals now being built under the program and will, therefore, result in more efficient expenditure of Federal and local funds and a better standard of patient care.

5. With regard to the effective date, H. R. 2176, H. R. 2567, and H. R. 3025 would increase the authorization and allotment base for the current fiscal year to $150,000,000 and would make the increased Federal participation effective for all projects approved on and after January 1, 1949. H. R. 3737 and H. R. 3515 would make the increased Federal participation effective for all projects approved on and after August 13, 1946, the date of original enactment.

We seriously question the wisdom of the retroactive features of these bills. These features would introduce a new principle in Federal grant-in-aid procedures. The objective of increasing the rate of Federal participation is to give greater encouragement and inducement to the States and communities to construct more needed hospitals. That objective is not furthered by a retroactive provision applying the increased rate to construction to which the States and communities are already committed. Also there is the difficulty of finding a logical stopping place, since any retroactive effective date short of the date on which the act was originally enacted must draw a somewhat arbitrary distinction between projects approved before and those approved after the effective date.

On behalf of the limited retroactivity provided for in H. R. 2176, H. R. 2567, and H. R. 3025 (i. e. to January 1, 1949), it may be argued that it is necessary, or at least expedient, in order to avoid the danger of having applicants postpone their construction projects until the enactment of the new bill. However that may be, no such argument can be made for a provision which is retroactive to August 13, 1946, and we strongly oppose this provision in H. R. 3737 and H. R. 3515.

The increase in the authorization for the current year is necessary if applications approved during the current year are to receive the increased Federal participation. In this connection one technical point should be noted. Increasing the Federal share of applications approved after January 1, 1949, may raise the total Federal participation beyond the allotments of some States for the years 1948 and 1949, even though the allotment for the year 1949 is doubled under the proposed bills. It is suggested therefore that if the act is made retroactive to January 1, 1949, consideration be given to making provision for increasing such States' allotments sufficiently to meet the deficit.

An additional appropriation of approximately $25,000,000 would be required to raise the Federal share of projects in which the Federal Government is now participating and which were approved prior to January 1, 1949, to the respective percentage of the several States. So broad a retroactive provision would result in a considerable number of States having projects approved for Federal shares beyond their 1948 and 1949 allotments, even taking into consideration the effect of doubling the 1949 allotments. Particularly will this be true in the 12 States where the amount of Federal participation will range from 65.47 to 75 per- [illegible] percentage

6. In addition to the amendments discussed above, there are a number of technical points on which out operating experience indicates that amendment of the act would be desirable. These points include the following: (*a*) incorporation into the basic act of the provisions of the 1948 and 1949 appropriation acts which (i) simplified the provisions for determining the total amount available for allotment to States for construction, and (ii) provided that the Federal share of the cost of construction of each approved project shall be a contractual obligation of the Federal Government; (*b*) increase of the minimum allotment in accordance with the increase in the allotment base from $75,000,000 to $150,-

000,000; (*c*) liberalization of the present strict requirement that an applicant for Federal assistance have sole title to the site of the proposed hospital; (*d*) relaxation of the present law's requirements that an application be filed by only one agency and that the hospital when completed be owned and operated by the agency filing the application; (*e*) amendment of the provision for recovery by the United States Government in the event the hospital ceases to be nonprofit in character to avoid implication that the Federal Government secures a lien on the hospital; and (*f*) provision for payment of the Federal share of construction payments direct to the applicant at the request of the State agency. Adoption of these amendments would involve some change in the wording, though none in the substance, of these bills. We should be glad to present our views on them in more detail at your committee's convenience.

We therefore recommend that one of the bills, modified as suggest above, be enacted by the Congress.

We are advised by the Bureau of the Budget that it has no objection to the submission of this report to your committee.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, May 31, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of May 19, 1949, for a report on H. R. 4771, a bill to amend section 1 of the act entitled "An act to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals" (Public Law 830, 80th Cong.).

This bill would amend section 1 of Public Law 830 so as to provide a minimum allotment of $250,000 to each State for the construction of hospitals under section 624 of the Public Health Service Act.

The following table shows the States which would receive increased allotments under the provisions of bill H. R. 4771.

State	Allotment for fiscal years—	
	1949 (actual)	1950 (tentative)
Alaska	$100,000	$100,000
Delaware	100,000	100,000
Montana	224,136	173,112
Nevada	100,000	100,000
North Dakota	[1] (287,847)	228,047
Vermont	227,131	217,719
Wyoming	146,879	118,776

[1] Allotment for 1949,exceeds the proposed minimum allotment.

We recommend that the minimum allotment be increased since on the basis of current construction costs, the present minimum Federal allotment of $100,000 is insufficient to permit the payment of the Federal share of the cost of constructing the average size hospital project approved under the program up to this time. Raising the minimum allotment to $250,000 would permit the construction of a hospital with a number of beds equal to or greater than that of the average size hospital project.

Section 2 of Public Law 830 authorizes such addditional appropriations as may be necessary to provide the increased minimum allotments under section 1. The additional amount which would be required if H. R. 47771 were enacted would be $612,346 per annum.

A technical consideration should be called to your attention. Since the bill is an amendment to Public Law 830, Eightieth Congress, rather than to the

Public Health Service Act, it might be interpreted as being effective retroactively with respect to allotments which have already been made for fiscal years 1948 and 1949. See opinion of the Comptroller General, dated August 24, 1948, with respect to Public Law 830. Such a result would create administrative difficulties and would operated to reduce the allotments of the States not affected by the provisions of the present bill in order to raise the allotments of those States which would be affected. To avoid these difficulties, it is suggested that the bill be amended to provide specifically that it shall not be effective with respect to allotments for fiscal years prior to the year ending June 30, 1950.

We would therefore recommend that, as so amended, the bill be enacted by the Congress.

The Bureau of the Budget advises that there is no objection to the submission of this report to your Committee.

Sincerely yours,

J. Donald Kingsley,
Acting Administrator.

Federal Security Agency,
Washington, June 30, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Chairman: This letter is in response to your requests of April 11, 1949, and February 4, 1949, for reports on H. R. 4126 and H. R. 2175. H. R. 4126 is a bill to amend the Public Health Service Act to increase the Federal payments for the construction of hospitals, and for other purposes. H. R. 2175 is a bill to amend sections 613, 624, 625, and 631 of the Hospital Survey and Construction Act (60 Stat. 1042, 1045–1047).

These bills would amend title VI of the Public Health Service Act so as to change the amount of Federal participation in individual projects from 33⅓ to 50 percent. H. R. 4126 would make the increased Federal share applicable to all hospitals approved as projects under the program on which construction has not been completed. An appropriation of such funds as would be necessary to increase the States' allotments sufficiently to meet the increased Federal share of hospitals approved as projects during the fiscal years ending June 30, 1950, and June 30, 1951, would be authorized. The provision for recovery by the United States Government in the event the hospital ceases to be nonprofit would be amended so as to coordinate the amount of recovery with the amount of Federal participation.

H. R. 2175 would also increase from 33⅓ to 50 percent the amount of Federal participation in expenditures for surveys and planning and would increase the amount of recovery from 33⅓ to 50 percent in the event the hospital ceases to be nonprofit.

We have the following comments with respect to the specific provisions of these bills:

In our report of May 20, 1949, on H. R. 2176, H. R. 2567, H. R. 3025, H. R. 3737, and H. R. 3515, we expressed and explained at some length the position of this Agency in favor of increasing the rate of Federal participation under title VI of the Public Health Service Act. As we said in that report, however, we believe that the increase should not be in the form of a flat uniform raising of the Federal share for all States and for all projects as proposed in the intsant bills, but we recommend instead that the new rates be permitted to vary within prescribed limits as between the States, taking into consideration the per capita income of the individual States. We also believe that, under stated conditions and within reasonable limits, each State should be permitted to vary the amount of Federal participation as between approved projects within the State, if it so desires, or, if it prefers a uniform rate of Federal participation for all projects in the State, that it be permitted to determine what that uniform rate shall be.

We seriously question the wisdom of the retroactive feature of H. R. 4126. This feature would introduce a new principle in Federal grant-in-aid procedures. The objective of increasing the rate of Federal participation is to give greater encouragement and inducement to the States and communities to construct more needed hospitals. That objective is not furthered by a retroactive provision applying the increased rate to construction to which the States and communities are already committed. Also there is the difficulty of finding a logical stopping place, since any retroactive effective date short of the date on which the act was originally enacted must draw a somewhat arbitrary distinction between projects approved before and those approved after the effective date. This arbitrary distinction is illustrated in the provision in H. R. 4126 which would deny the retroactive increase to hospitals already completed but would grant it to those which are 99 percent completed at the time the bill becomes law.

On behalf of the limited retroactivity provided for in H. R. 2176, H. R. 2567, and H. R. 3025 (i. e., to January 1, 1949), we stated in our report of May 20, 1949, that it may be argued that it is necessary, or at least expedient, in order to avoid the danger of having applicants postpone their construction projects until the enactment of the new bill. However that may be, no such argument can be made for a retroactive provision, such as that contained in H. R. 4126, which would make the increased Federal share applicable to projects for which no increase in Federal participation was anticipated at the time they were approved and with respect to which there has been no danger of delay.

H. R. 2175 makes no provision for an appropriation of necessary funds to take care of the proposed increase in the Federal share. H. R. 4126 provides for an appropriation of necessary funds to increase the States' allotments sufficiently to meet the 50 percent Federal share of hospitals approved as projects during the fiscal years ending June 30, 1950, and June 30, 1951. However, although under the proposed bill the Federal share would be increased from 33⅓ percent to 50 percent for all projects on which construction has not been completed, no provision is made for an additional appropriation to cover the increased cost to the Federal Government of projects chargeable to the 1948 and 1949 allotments. Based on projects approved as of March 31, 1949, it is estimated that the Federal share for these projects will be increased to $108,000,000 for 1948 and $84,000,000 for 1949 as opposed to the present cost of $72,000,000 for 1948 and $56,000,000 for 1949. In addition, the total Federal cost would be increased proportionately on projects approved between March 31, 1949, and June 30, 1949. Thus, increasing the Federal share retroactively as proposed would result in raising the total Federal participation beyond the allotments of practically all States for the years 1948 and 1949. It is suggested, therefore, that, should the retroactive provision be enacted, consideration be given to making provision for increasing such States' allotments sufficiently to meet the deficit. Should H. R. 2175 be enacted, provision should be made for an appropriation of necessary funds to increase the States' allotments sufficiently to meet the 50 percent Federal share

As stated above, H. R. 2175 proposes to increase from 33⅓ percent to 50 percent the amount of Federal participation in expenditures for surveys and planning. In our report of May 20, 1949, we recommended the enactment of a law which would authorize the expenditure of Federal funds for State administrative expenses to supplement State expenditures on a matching basis. Survey and planning functions are now so closely correlated with other administrative functions that it is difficult to separate them from such other functions. The enactment of the provisions which we have recommended would authorize Federal participation in all State administrative expenses incurred in the program, including expenditures for survey and planning, and would eliminate the need for the proposed amendment.

With respect to the proposals in the two bills to amend the law relative to the amount of Federal recovery in the event the hospital ceases to be nonprofit, we prefer that contained in H. R. 4126 because it coordinates more clearly the amount of recovery with the amount of Federal participation.

H. R. 2176, H. R. 2567, H. R. 3025, H. R. 3737, H. R. 3515, S. 614, and S. 1581, all of which are identical in most respects, contain provisions for extending the program, increasing allotments and making other substantive changes. Although we are in accord with the objectives of H. R. 4126 and H. R. 2175, we prefer the enactment of one of the other bills modified as suggested in our reports of May 2, 1949, and May 20, 1949.

The Bureau of the Budget advises that, insofar as that Bureau is concerned, there is no objection to the submission of this report to your committee.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, June 30, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your request of April 14, 1949, for a report on H. R. 4215, a bill to amend title VI of the Public Health Service Act to provide additional Federal aid in the construction of hospitals, to provide Federal aid in the maintenance and operation of hospitals, and for other purposes.

As indicated in the title, the bill has two principal parts. The first eight sections are devoted generally to amending the existing title VI of the Public Health Service Act, as added by the Hospital Survey and Construction Act (Public Law No. 725, 79th Cong.), to increase the authorization for appropriation to $150,000,000 annually, extend the program through the fiscal year 1955, change the rate of Federal participation in individual projects from the present flat one-third to the State's allotment percentage (which would range from 33⅓ percent to 75 percent), authorize the Surgeon General to conduct research, demonstrations, and experiments with respect to the utilization and coordination of hospital facilities, and to make grants for similar purposes, and make provision with respect to administrative expenses of the State agency. In these respects the bill is very similar to H. R. 2176, 2567, 3025, 3737, and 3515 on which we have already commented in our letter to you of May 20, 1949. We do not believe that any additional statement on these points is necessary at this time except for one point which has been added in this bill. Section 5 (b) of H. R. 4215 provides that 2 percent of the State's allotment shall be available to pay costs incurred by the State in administering the State plan. As indicated in our letter of May 20, 1949, we would favor Federal grants to assist States in the expense of administering their State plans. However, we do believe that 2 percent of the State's annual allotment would not be a satisfactory formula for determining the amount to be made available to the State for administrative expenses. In place of section 5 (b) we should suggest substituting the provisions of section 303 of the so-called omnibus health bill, H. R. 4312 and H. R. 4313 (identical bills), on which we commented in our letter to you of May 19, 1949. This provides a formula more closely allied to the needs of the individual States, requires the States to match the Federal contributions, establishes a procedure for payment of the funds and does not use the administrative expenses to reduce the State's construction allotment. We also believe that section 5 (b) is inconsistent with section 6, which requires the States to put up at least 2 percent of the total funds proposed to be expended during the year under the State plan.

In addition to the amendments to the existing Hospital Survey and Construction Act, the bill also adds a new part to title VI of the Public Health Service Act, providing for Federal grants to public and other nonprofit hospitals for expenses of maintenance and operation. The bill would authorize the appropriation of $50,000,000 annually for this purpose to be allotted to the States by the same formula that is now contained in the Hospital Survey and Construction Act. Allotments would be made available to States whose plans have been approved under section 643. Payments would be made out of the State's allotments to public and other nonprofit hospitals in the State for expenses of maintenance and operation in proportion to their relative need. The amount of such payments would be determined by the State agency but could not be less than 33⅓ percent or more than the State's allotment percentage of the cost of maintenance and operation of the hospital. Presumably the percentage would be related to the annual cost of operation of the particular hospital, although this is not specifically stated. Applications would be submitted to the Surgeon General through the State agency and would have to be approved by the State agency before they could be approved by the Surgeon General. As in the case of the amendment to the Hospital Survey and Construction Act, 2 percent of the State's annual allotment would be available for administrative expenses.

This agency is sympathetic to the general purpose of this provision of the bill to provide hospitals with financial support for their maintenance and operation. There can be no doubt that hospitals in this country are facing very serious financial problems because of the increase in operating costs beyond the point which could be offset by increased charges. The cost of affording adequate hospital care has risen to such a point that it may well be that governmental assistance in some form represents the only solution to this problem. As was stated in our report on H. R. 4312 and H. R. 4313, this agency favors the adoption of a national system of prepaid health and hospital insurance. We believe that adoption of such a system would furnish patients with sufficient medical purchasing power to enable them to meet the costs of hospital care and that such a system would in the long run be preferable to the approach proposed in H. R. 4215. However, the financial condition of some hospitals may make governmental action necessary before the enactment of health insurance, as a stopgap measure. This agency is currently studying this problem with representatives of hospital associations.

In view of the urgent request from the committee clerk for submission of this report because of the commencement of hearings on this and related bills, time has not permitted the submission of this report to the Bureau of the Budget for advice as to the relationship of the bill to the program of the President.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

FEDERAL SECURITY AGENCY,
Washington, June 30, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CHAIRMAN: This letter is in response to your requests of May 19, 1949, and June 2, 1949, for reports on H. R. 4763 and 4944. These bills, which are identical, are bills to amend Public Law 725, Seventy-ninth Congress, section 624.

The two bills would amend section 624 to provide for additional allotments to each State in the amount of $6 per capita of increase in the population since 1940. The State agency is directed to allot these funds to the areas in the State showing the increase in population. In allotting these funds the State agency would be required to take into consideration the utilization of present hospital facilities and to give priority to additions to hospitals showing the greater number of admissions in relation to the number of beds. Hospitals, in general, would be required to have more than the general average of admissions per bed; that is, more than 22 patients per bed per year.

The present allotments are based on population and per capital income, with strong weighting given to the income factor. The amendment would give large aloltment increases to States with substantial increases in population since 1940 and would have the net result of diminishing considerably the weighting given to income.

As shown by the attached table, all except seven States had an increase in population between 1940 and July 1, 1948. The total increase in population in the States having such increase was 15,100,000. Therefore, the total additional funds which would be allotted under the provisions of these bills would amount to $90,700,000. Seven States (Arkansas, Kentucky, Mississippi, Montana, Nebraska, North Dakota, South Dakota) would receive no additional allotments. A major portion of the total would go to nine States: California, 18.7 million dollars; Illinois, 4.6 million dollars; Michigan, 5.6 million dollars; New York, 5.4 million dollars; Ohio, 5.3 million dollars; Oregon, 3.2 million dollars; Pennsylvania, 4.7 million dollars; Texas, 4.8 million dollars; and Washington, 4.5 million dollars.

Many States, despite their population increases, are relatively better off as regards hospital facilities available to their present population than some which have had no increase. For example, California, which would receive an additional $18,000,000 allotment under the amendment, has 2.9 acceptable general hospital beds per 1,000 population, whereas Mississippi, which would receive no additional allotment, now has only 1.7 beds per 1,000 of the present population. It should be emphasized, however, that the present formula already takes account of population increase, since the population figures used in calculating the annual allotments are the latest population estimates certified by the Department of Commerce. For example, the tentative 1950 allotment of California, based on the 1948 population, is approximately $2,499,000. If California's allotment were based on its 1940 population, its allotment would be in the neighborhood of only $1,700,000.

In addition to the above considerations, the provisions of these bills are totally unrelated to the requirements of the State plan set out in section 623 of the basic act, and in some instances might operate inconsistently with such requirements.

The provision providing for the allotment of additional funds to areas in the State showing an increase in population might well conflict with the requirement of section 623 (a) (5), which provides for construction, insofar as possible, in the order of relative need, since there might be some areas of the State, which although they have had no increase in population since 1940, are nevertheless less equipped with hospital facilities than communities which have had an increase in population. A practical difficulty, moreover, is that official estimates of the current population of cities and counties within the State may not be available. Likewise, the requirement that hospitals applying for construction funds to add to existing facilities be given priority on the basis of greater utilization may operate inconsistently with the requirement of regard to relative need. Also, the specification that, in allotting funds, the State agency take into consideration the utilization of present hospital facilities—to be measured by dividing admissions by the number of beds—could result in all of the allotments under this amendment going into general hospital beds, to the exclusion of mental, tuberculosis, and chronic-disease beds.

In view of the above objections, it would appear that the proposed amendment is not a desirable one. We therefore recommend that it not be enacted.

In view of the fact that this report is urgently desired because of the current hearings on these and related bills, we are submitting this report without having obtained advice from the Bureau of the Budget as to the relationship of these bills to the program of the President.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

Increase in population, by State, 1940–48, and additional State allotments, under H. R. 4763 and H. R. 4944

State	1940 population	July 1, 1948, population	Increase	Allotment increase×($6)
Total	134, 059, 273	148, 906, 000	15, 125, 727	$90, 754, 338
Alabama	2, 832, 961	2, 848, 000	15, 039	90, 234
Arizona	499, 261	664, 000	164, 739	988, 434
Arkansas	1, 949, 387	1, 925, 000		
California	6, 907, 387	10, 031, 000	3, 123, 613	18, 741, 678
Colorado	1, 123, 296	1, 165, 000	41, 704	250, 224
Connecticut	1, 709, 242	2, 011, 000	301, 758	1, 810, 548
Delaware	266, 505	297, 000	30, 495	182, 970
District of Columbia	663, 091	898, 000	234, 909	1, 409, 454
Florida	1, 897, 414	2, 356, 000	458, 586	2, 751, 516
Georgia	3, 123, 723	3, 128, 000	4, 277	25, 662
Idaho	524, 873	530, 000	5, 127	30, 762
Illinois	7, 897, 241	8, 670, 000	772, 759	4, 636, 554
Indiana	3, 427, 796	3, 909, 000	481, 204	2, 887, 224
Iowa	2, 538, 268	2, 625, 000	86, 732	520, 392
Kansas	1, 801, 028	1, 968, 000	166, 972	1, 001, 832
Kentucky	2, 845, 627	2, 819, 000		
Louisiana	2, 363, 880	2, 576, 000	212, 120	1, 272, 720
Maine	847, 226	900, 000	52, 774	316, 644
Maryland	1, 821, 244	2, 148, 000	326, 756	1, 960, 536
Massachusetts	4, 316, 721	4, 718, 000	401, 279	2, 407, 674
Michigan	5, 256, 106	6, 195, 000	938, 894	5, 633, 364
Minnesota	2, 792, 300	2, 940, 000	147, 700	886, 200
Mississippi	2, 183, 796	2, 121, 000		
Missouri	3, 784, 664	3, 947, 000	162, 336	974, 016
Montana	559, 456	511, 000		
Nebraska	1, 315, 834	1, 301, 000		
Nevada	110, 247	142, 000	31, 753	190, 518
New Hamsphire	491, 524	548, 000	56, 476	338, 856
New Jersey	4, 160, 165	4, 729, 000	568, 835	3, 413, 010
New Mexico	531, 818	571, 000	39, 182	235, 092
New York	13, 479, 142	14, 386, 000	906, 858	5, 441, 148
North Carolina	3, 571, 623	3, 715, 000	143, 377	860, 262
North Dakota	641, 935	560, 000		
Ohio	6, 907, 612	7, 799, 000	891, 388	5, 348, 328
Oklahoma	2, 336, 434	2, 362, 000	25, 566	153, 396
Oregon	1, 089, 684	1, 626, 000	536, 316	3, 217, 896
Pennsylvania	9, 900, 180	10, 689, 000	788, 820	4, 732, 920
Rhode Island	713, 346	748, 000	34, 654	207, 924
South Carolina	1, 899, 804	1, 991, 000	91, 196	547, 176
South Dakota	642, 961	623, 000		
Tennessee	2, 915, 841	3, 149, 000	233, 159	1, 398, 954
Texas	6, 414, 824	7, 230, 000	815, 176	4, 891, 056

Increase in population, by State, 1940–48, and additional State allotments, under H. R. 4763 and H. R. 4944—Continued

State	1940 population	July 1, 1948, population	Increase	Allotment increase × ($6)
Utah	550, 310	655, 000	104, 690	$628, 140
Vermont	359. 231	374, 000	14, 769	88, 614
Virginia	2, 677, 773	3, 029, 000	351, 227	2, 107, 362
Washington	1, 736, 191	2, 487, 000	750, 809	4, 504, 854
West Virginia	1, 901, 974	1, 915, 000	13, 026	78, 156
Wisconsin	3, 137, 587	3, 309. 000	171, 413	1, 028, 478
Wyoming	250, 742	275. 000	24. 258	145, 548
Alaska	[1] 72, 524	73, 000	476	2, 856
Hawaii	423, 330	544. 000	120. 670	721. 020
Puerto Rico	1, 869, 255	2, 149, 000	279, 745	1, 678, 470
Virgin Islands	24, 889	27, 000	2, 111	12, 666

[1] Census taken as of Oct. 1 of the preceding year.

VETERANS' ADMINISTRATION,
Washington 25, D. C., March 21, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of Febuary 11, 1949, requesting a report by the Veterans' Administration on H. R. 323, Eighty-first Congress, a bill to amend section 1 of the act entitled "An act to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals" (Public Law 830, 80th Cong.).

H. R. 323, Eighty-first Congress, would amend section 624 of the Public Health Service Act, as amended (42 U. S. C. 291g), to set a minimum of $250,000 on the annual construction allotments for any State under the hospital construction provisions of the act. Under existing law the minimum allotment is $100,000.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., Aug. 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people, and (2) to construct publc and other nonprofit hospitals in accordance with such programs.

The Hospital Survey and Construction Act as originally enacted provided that any State with an approved plan for construction of hospitals and public health centers would be entitled to an annual allotment out of which Federal assistance would be payable to public and other nonprofit agencies for construction of hospital facilities, the amount of the allotment to be determined by a formula written into the law based on population and per capita income. No minimum allotment, however, was provided. Public Law 830, Eightieth Congress, June 29, 1948, amended the Hospital Survey and Construction Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals. H. R. 4816, Eightieth Congress, which became Public Law 830, originally provided a minimum allotment of $250,000. However, the bill was amended in the Senate to provide the lower amount and the House of Representatives agreed to the Senate amendment.

The Veterans' Administration would not be charged with any duties and responsibilities under the proposed legislation and is, therefore ,not in a position to submit an estimate of the cost of the proposal. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that office to the submission of this report to your committee.

Sincerely yours,

CARL R. GRAY, Jr., *Administrator.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., March 23, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of February 10, 1949, requesting a report by the Veterans' Administration on H. R. 991, Eighty-first Congress, a bill to amend the Public Health Service Act to provide assistance for the construction of hospitals furnishing domiciliary care.

H. R. 991, Eighty-first Congress, would amend section 631 (e) of the Public Health Service Act, as amended (42 U. S. C. 291i) to include in the definition of the term "hospital" as used in the hospital survey and construction provisions of the act, except as used in section 622 (a) and (b), hospitals furnishing primarily domiciliary care. The Hospital Survey and Construction Act specifically excludes from the definition of the term "hospital" any hospital furnishing primarily domiciliary care.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., Aug. 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, Construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their exising hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people and (2) to construct public and other nonprofit hospitals in accordance with such programs.

Inasmuch as the Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation, it is not in a position to submit an estimate of cost of the proposal. It is assumed that your committee will desire the views of the Federal Security Administrator, under whose jurisdiction and the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that office to the submission of this report to your committee.

Sincerely yours,

CARL R. GRAY, Jr., *Administrator.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., April 15, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of February 15, 1949, requesting a report by the Veterans' Administration on H. R. 1721, Eighty-first Congress, a bill to amend the Public Health Service Act to authorize the payment of prior construction costs of certain hospitals approved as projects under such act.

Section 1 of the bill would amend section 625 of the Public Health Service Act, as amended by the Hospital Survey and Construction Act (42 U. S. C. 291h), by adding at the end thereof a new subsection, (f), so as to permit the Surgeon General of the Public Health Service, with the concurrence of the State hospital construction agency, to waive compliance with any requirement of subsection (a), which subsection relates to applications for and approval of Federal hospital construction grants, with respect to construction commenced on the hospital prior to the date of such approval, if he finds that the purpose of such requirement has been accomplished, and to certify funds sufficient to pay 33⅓ percent of the cost of such prior construction, if funds are available for the purpose from the allotment to the State. This amendment would be effective only in the case of any hospital on which construction began after May 1, 1946, and before July 1, 1948, which is approved by the Surgeon General as a project with respect to that part of the construction of the hospital to be undertaken after the date of such approval.

Section 2 of the bill would amend section 631 (i) of the Public Health Service Act, as amended (42 U. S. C. 291i (i)) so as to include in the definition of the term "cost of construction" those costs incurred prior to date of approval, in the case of any hospital on which construction has been commenced after May 1, 1946, and prior to July 1, 1948, and which is approved as a project with respect to that part of the construction to be undertaken after the date of such approval.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., August 13, 1946), amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944), by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people and (2) to construct public and other nonprofit hospitals in accordance with such programs.

The Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator, under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection to the submission of this report to your committee.

Sincerely yours,

O. W. CLARK
(for Carl R. Gray, Jr., Administrator).

VETERANS' ADMINISTRATION,
Washington 25, D. C., June 16, 1949.

HON. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of February 10, 1949, requesting a report by the Veterans' Administration on H. R. 2175, Eighty-first Congress, a bill to amend sections 613, 624, 625, and 631 of the Hospital Survey and Construction Act (60 Stat. 1042, 1045–1047).

The purpose of the bill is to amend sections 613, 624, 625, and 631 of the Public Health Service Act, as amended (42 U. S. C. 291c, 291g, 291h, 291i), to increase the amount of Federal participation in the costs of inventorying existing hospitals, of surveying the need for construction of hospitals and of constructing hospitals, from 33⅓ percent to 50 percent.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., August 13, 1946) amended the Public Health Service (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people, and (2) to construct public and other nonprofit hospitals in accordance with such programs.

Your attention is invited to H. R. 4312, Eighty-first Congress, "a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes," title III of which, if enacted, would be cited as the "Hospital Survey and Construction Amendments of 1949." One of the purposes of this title is to increase the amount of Federal participation in the costs of construction of projects and permit variation of such amount within a State in accordance with State standards. Should H. R. 4312 be enacted, the Federal contribution would range from one-third to two-thirds of the cost of construction.

The Veterans' Administration would not be charged with any duties and responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that Office to the presentation of this report to your committee.

Sincerely yours,

O. W. CLARK
(For Carl R. Gray, Jr., Administrator).

VETERANS' ADMINISTRATION,
Washington 25, D. C., May 13, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letters of February 10, 1949, February 11, 1949, and March 1, 1949, requesting reports on substantially identical bills, H. R. 2176, H. R. 2567, and H. R. 3025, Eighty-first Congress, enttiled "A bill to amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act), to extend its duration and provide greater financial assistance in the construction of hospitals, and for other purposes."

The bills which would amend the Public Health Service Act, as amended by the Hospital Survey and Construction Act (42 U. S. C. 291–291m), have for their general purpose (1) increasing the amount of Federal aid from $75,000,000 a year to $150,000,000 a year and extending the time for the operation of the act; (2) placing the Federal allotment for the individual projects on the same variable need basis as the over-all allotment to the particular State so that the Federal contribution to individual projects would vary between 33⅓ percent and 75 percent; and (3) providing Federal funds for aid to States, political subdivisions, universities, hospitals, and other public and private nonprofit institutions or organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources.

It is observed that both in line 17, page 2, of H. R. 2176, and in line 17, page 2, of H. R. 3025, reference is made to 623 (e). It would appear from the context that 625 (e) is the intended reference. The context also indicates the inadvertent omission of the words "agreement of" after the words "determined by" in line 19, page 2, of H. R. 3025.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., August 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people and (2) to construct public and other nonprofit hospitals in accordance with such programs.

The Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator, under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that Office to the presentation of this report to your committee.

Sincerely yours,

CARL R. GRAY, Jr., *Administrator.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., April 15, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of March 1, 1949, requesting a report by the Veterans' Administration on H. R. 3070, Eighty-first Congress, a bill to amend the Hospital Survey and Construction Act.

Section 1 of the bill would amend section 625 (a) of the Public Health Service Act, as amended by the Hospital Survey and Construction Act (42 U. S. C. 291h (a)), which subsection relates to applications for and approval of Federal hospital construction grants, so as to permit the Surgeon General of the Public Health Service, with the concurrence of the State hospital construction agency, to waive compliance with any requirement of the subsection if he finds its purpose has been fulfilled, in the case of any project on which construction has begun between August 13, 1946 (effective date of the Hospital Survey and Construction Act) and the date of approval of the State plan. Section 2 of the bill would amend section 631 (i) of the act (42 U. S. C. 291i (i)) so as to include in the definition of the term "cost of construction" in the case of projects on which construction has begun after August 13, 1946, and before approval of the State plan, costs incurred before such approval.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., August 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people and (2) to construct public and other nonprofit hospitals in accordance with such programs.

H. R. 3070, Eighty-first Congress, is identical with H. R. 5807, Eightieth Congress, which passed the House of Representatives on June 16, 1948. The Veterans' Administration was not requseted to report on that bill.

The Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator, under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection to the submission of this report to your committee.

Sincerely yours,

O. W. Clark
(For Carl R. Gray, Jr., Administrator).

Veterans' Administration,
Washington 25, D. C., June 16, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Crosser: Further reference is made to your letters of March 15 and March 25, 1949, requesting reports on substantially identical bills H. R. 3515 and H. R. 3737, Eighty-first Congress, each entitled, "A bill to amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act), to extend its duration and provide greater financial assistance in the construction of hospitals, and for other purposes."

The bills, which would amend the Public Health Service Act, as amended by the Hospital Survey and Construction Act (42 U. S. C. 291–291m), have for their general purpose (1) increasing the amount of Federal aid from $75,000,000 a year to $150,000,000 a year, and extending the time for the operation of the act; (2) placing the Federal allotment for the individual projects on the same variable need basis as the over-all allotment to the particular State so that the Federal contribution to individual projects would vary between 33⅓ and 75 percent; and (3) providing Federal funds for aid to States, political subdivisions, universities, hospitals, and other public and private nonprofit institutions or organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources. The effective date would be the date of enactment, except that the amendments placing the Federal allotment for the individual projects on the same variable need basis as the over-all allotment to the particular State would be effective with respect to projects approved under section 625 of the Public Health Service Act on and after August 13, 1946, and the section relative to studies and demonstrations relating to coordinated use of hospital facilities would be effective July 1, 1949.

It is observed that both in line 3, page 3, H. R. 3515, and in line 1, page 3, of H. R. 3737, reference is made to "623 (e)." It would appear from the context that "625 (e)" is the intended reference. In line 6, page 2, of H. R. 3515, reference is made to "524." It would appear that "624" is the intended reference. The context also indicates in line 16, page 4, of H. R. 3737, the inadvertent omission after the words "fiscal years" of ", and such amounts for such succeeding fiscal years."

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., August 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals.

The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic and similar services to all their people and (2) to construct public and other nonprofit hospitals in accordance with such programs.

Your attention is invited to H. R. 4312, Eighty-first Congress, a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes, which bill is related to the remommendations of the President of the United States as contained in his message to the Congress of April 22, 1949, advocating the enactment of a comprehensive national health program. Title III of H. R. 4312, if enacted, would be cited as the "Hospital Survey and Construction Amendments of 1949." Its purpose is to amend the hospital survey and construction provisions of the Public Health Service Act so as to extend the duration of those provisions until June 30, 1957; to increase the amount authorized to be allotted among the States for assisting in meeting the costs of construction of hospitals; to authorize increases in the amount of Federal participation in the costs of construction of projects and permit variation of the amount within a State in accordance with State standards; to include in the program specifically, and to give necessary emphasis to construction of, facilities for group medical and dental practice; to authorize studies on the coordinated use of hospital facilities on a regional area basis; and otherwise to improve the hospital survey and construction provisions of the Public Health Service Act. Certain provisions similar to those contained in H. R. 3515 and H. R. 3737 are included in H. R. 4312

The Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator, under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection by that Office to the presentation of this report to your committee.

Sincerely yours,

O. W. Clark
(For Carl R. Gray, Jr., Administrator).

Veterans' Administration,
Washington 25, D. C., June 3, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

Dear Mr. Crosser: Further reference is made to your letter of May 19, 1949, requesting a report by the Veterans' Administration on H. R. 4771, Eighty-first Congress, a bill to amend section 1 of the act entitled "An act to amend section 624 of the Public Health Service Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals" (Public Law 830, 80th Cong.).

H. R. 4771, Eighty-first Congress, would amend section 624 of the Public Health Service Act, as amended (42 U. S. C. 291g) to set a minimum of $250,000 on the annual construction allotments for any State under the hospital construction provisions of the act. Under existing law the minimum allotment is $100,000.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., Aug. 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people, and (2) to construct public and other nonprofit hospitals in accordance with such programs.

As originally enacted the Hospital Survey and Construction Act provided that any State with an approved plan for construction of hospitals and public health centers would be entitled to an annual allotment out of which Federal assistance would be payable to public and other nonprofit agencies for construction of hospital facilities, the amount of the allotment to be determined by a formula written into the law based on population and per-capita income. No minimum allotment, however, was provided. Public Law 830, Eightieth Congress, June 29, 1948, amended the Hospital Survey and Construction Act so as to provide a minimum allotment of $100,000 to each State for the construction of hospitals. H. R. 4816, Eightieth Congress, which became Public Law 830, originally provided a minimum allotment of $250,000. However, the bill was amended in the Senate to provide the lower amount and the House of Representatives agreed to the Senate amendment.

Your attention is invited to H. R. 4312, Eighty-first Congress, a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes, title III of which, if enacted, would be cited as the "Hospital Survey and Construction Amendments of 1949." Section 307 of H. R. 4312 proposes to amend section 624 of the Public Health Service Act, as amended. The amendment proposed would increase the minimum annual construction allotment to $200,000.

The Veterans' Administration would not be charged with any duties and responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice was received from the Bureau of the Budget that there was no objection to the similar report of the Veterans' Administration to your committee on H. R. 323, Eighty-first Congress, which is identical with this bill.

Sincerely yours,

CARL R. GRAY, Jr., *Administrator.*

VETERANS' ADMINISTRATION,
Washington 25, D. C., June 28, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of April 11, 1949, requesting a report by the Veterans' Administration on H. R. 4126, Eighty-first Congress, a bill to amend the Public Health Service Act to increase the Federal payments for the construction of hospitals, and for other purposes.

The bill would amend sections 624 and 625 (a) and (b) of the Public Health Service Act, as amended (42 U. S. C. 291g, 291h (a) (b)), to increase from 33⅓ percent to 50 percent the amount of Federal participation in the cost of construction of hospitals. Section 625 (e) of the Public Health Service Act, as amended (42 U. S. C. 291h (e)), would also be amended to change the amount of recovery by the United States in the event of sale or transfer of a hospital to an agency not qualified under the act, or in the event a hosptial ceases to be a nonprofit hospital, from 33⅓ percent of the then value of the hospital to an amount bearing the same ratio to the then value of the hospital as the amount of Federal participation bore to the cost of construction.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., Aug. 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof title VI, construction of hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people, and (2) to construct public and other nonprofit hospitals in accordance with such programs.

Your attention is invited to H. R. 4312, Eighty-first Congress, a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes, title III of which, if enacted, would be cited as the "Hospital Survey and Construction Amendments of 1949." One of the purposes of this title is to increase the amount of Federal participation in the costs of construction of projects and permit variation of such amount within a State in accordance with State standards. Should H. R. 4312 be enacted, the Federal contribution would range from one-third to two-thirds of the cost of construction.

The Veterans' Administration would not be charged with any duties and responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Advice has been received from the Bureau of the Budget that there would be no objection to the presentation of this report to your committee.

Sincerely yours,

O. W. CLARK
(For Carl R. Gray, Jr., Administrator).

VETERANS' ADMINISTRATION,
Washington, D. C., June 28, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

DEAR MR. CROSSER: Further reference is made to your letter of April 14, 1949, requesting a report by the Veterans' Administration on H. R. 4215, Eighty-first Congress, a bill to amend title VI of the Public Health Service Act to provide additional Federal aid in the construction of hospitals, to provide Federal aid in the maintenance and operation of hospitals, and for other purposes.

The bill, which would amend the Public Health Service Act, as amended by the Hospital Survey and Construction Act (42 U. S. C. 291–291m), has for its general purpose (1) increasing from $75,000,000 to $150,000,000 a year the amount of Federal aid authorized to be appropriated for assistance to the States in constructing public and other nonprofit hospitals and extending the time for the operation of the act; (2) placing the Federal allotment for the individual projects on the same variable-need basis as the over-all allotment to the particular State so that the Federal contribution to individual projects would vary between 33⅓ and 75 percent; (3) providing Federal funds for aid to States, political subdivisions, universities, hospitals, and other public and private nonprofit institutions or organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources; and (4) authorizing Federal funds to assist the States in the maintenance and operation of public and other nonprofit hospitals.

The Hospital Survey and Construction Act (Public Law 725, 79th Cong., August 13, 1946) amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof Title VI, Construction of Hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people and (2) to construct public and other nonprofit hospitals in accordance with such programs.

Your attention is invited to H. R. 4312, Eighty-first Congress, a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes, which bill is related to the recommendations of the President of the United States as contained in his message to the Congress of April 22, 1949, advocating the enactment of a comprehensive national health program. Title III of H. R. 4312, if enacted, would be cited as the Hospital Survey and Construction Amendments of 1949. Its purpose is to amend the hospital survey and construction provisions of the Public Health Service Act so as to extend the duration of those provisions until June 30, 1957; to increase the amount authorized to be allotted among the States for assisting in meeting the costs of construction of hospitals; to authorize increases in the amount of Federal participation in the costs of construction of projects and permit variation of the amount within a State in accordance with State standards; to include in the program specifically, and to give necessary emphasis to construction of, facilities for group medical and dental practice; to authorize studies on the coordinated use of hospital facilities on a regional-area basis; and otherwise to improve the hospital survey and construction provisions of the Public Health Service Act.

Certain provisions similar to those contained in H. R. 4215 are included in H. R. 4312.

The Veterans' Administration would not be charged with any duties or responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator, under whose jurisdiction the provisions of the Public Health Service Act are administered.

Due to the urgent request of the committee for a report on this measure, there has not been sufficient time in which to ascertain from the Bureau of the Budget the relationship of the proposed legislation to the program of the President.

Sincerely yours,

O. W. Clark
(For Carl R. Gray, Jr., Administrator).

Veterans' Administration,
Washington, D. C., June 28, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington, D. C.

Dear Mr. Crosser: Further reference is made to your letters of May 19, and June 2, 1949, requesting reports by the Veterans' Administration on identical bills H. R. 4763 and H. R. 4944, Eighty-first Congress, entitled "A bill to amend Public Law 725, Seventy-ninth Congress, section 624."

The apparent purpose of the bills, as indicated by the title above-quoted, is to implement section 624 of Public Law 725, Seventy-ninth Congress, the Hospital Survey and Construction Act (42 U. S. C. 291g). The bills are not drafted in the form of an amendment to section 624 but it is assumed that their provisions would constitute an addition to the section rather than a substitute therefor. It appears that the bills are intended to provide allotments to each State based on the population increase in that State calculated from the Federal census of 1940 as compared to estimate of State population by the Census Bureau at the time of the allotment of funds, these allotments to be in addition to allotments already afforded the States for assistance in constructing public and other nonprofit hospitals. Allocation of these additional funds would be made by the responsible State agency in accordance with criteria set out in the bills.

The Hospital Survey and Construction Act amended the Public Health Service Act (Public Law 410, 78th Cong., July 1, 1944) by adding at the end thereof Title VI, Construction of Hospitals. The purpose of the act is to assist the several States (1) to inventory their existing hospitals, to survey the need for construction of hospitals, to develop programs for construction of such public and other nonprofit hospitals as will, in conjunction with existing facilities, assure the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people; and (2) to construct public and other nonprofit hospitals in accordance with such programs.

Your attention is invited to H. R. 4312, Eighty-first Congress, a bill to provide a program of national health insurance and public health and to assist in increasing the number of adequately trained professional and other health personnel, and for other purposes, which bill is related to the recommendations of the President of the United States as contained in his message to the Congress of April 22, 1949, advocating the enactment of a comprehensive national health program. Title III of H. R. 4312, if enacted, would be cited as the "Hospital Survey and Construction Amendments of 1949." Its purpose is to amend the hospital survey and construction provisions of the Public Health Service Act so as to extend the duration of those provisions until June 30, 1957; to increase the amount authorized to be allotted among the States for assisting in meeting the costs of construction of hospitals; to auhorize increases in the amount of Federal participation in the costs of construction of projects and permit variation of the amount within a State in accordance with State standards; to include in the program specifically, and to give necessary emphasis to construction of, facilities for group medical and dental practice; to authorize studies on the coordinated use of hospital facilities on a regional area basis; and otherwise to improve the hospital survey and construction provisions of the Public Health Service Act.

The Veterans' Administration would not be charged with any duties and responsibilities under the proposed legislation. It is assumed that your committee will desire the views of the Federal Security Administrator under whose jurisdiction the provisions of the Public Health Service Act are administered.

Due to the urgent request of the committee for a report on this measure, there has not been sufficient time in which to ascertain from the Bureau of the Budget the relationship of the proposed legislation to the program of the President.

Sincerely yours,

O. W. CLARK
(For Carl R. Gray, Jr., Administrator).

DEPARTMENT OF THE INTERIOR,
OFFICE OF THE SECRETARY,
Washington 25, D. C., September 3, 1949.

Hon. ROBERT CROSSER,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives.

MY DEAR MR. CROSSER: This is in reply to your request for this Department's views on H. R. 2567, H. R. 3515, H. R. 3025, H. R. 2176, H. R. 4215, H. R. 3737, similar bills to amend the Hospital Survey and Construction Act (title VI of the Public Health Service Act), to extend its duration and provide greater financial assistance in the construction of hospitals, and for other purposes.

The bills would make several major changes in title VI of the Public Health Service Act (60 Stat. 1040; 42 U. S. C., 1946 ed., sec. 291–291m).

Under section 2 of the bills (sec. 4 of H. R. 4215), the total Federal allotment provided to the States, Territories, and possessions for hospital construction purposes would be increased from $75,000,000 to $150,000,000, and the program would be extended for an additional 4-year period through 1955. Under section 3 of the bills (sec. 5 of H. R. 4215), the Federal share in the construction costs of an individual hospital project would be changed from the present limit of 33⅓ percent in all cases to the allotment percentage of the State, Territory, or possession in which the project is to be built, thus permitting a Federal grant which may vary from a minimum of 33⅓ percent to a maximum of 75 percent. Section 5 of the bills (sec. 8 of H. R. 4215) would add a new section to the act, section 636, which would authorize the Surgeon General to make grants for and to conduct research, experiments, and demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources. Section 4 of the bills (sec. 6 of H. R. 4215) would add a new provision to section 625 of the act which would authorize the Surgeon General to without certification of construction payments to any State on a finding that State funds provided for direct administration of the State plan are less than $15,000 or 2 percent of the total fund to be expended under the plan, whichever is higher. The apparent purpose of this latter provision of the bills is to require the States, Territories, or possessions to provide for adequate staffs to administer the plans for hospital construction.

Although the objective of providing for an adequate staff is sound, I seriously question the desirability of making this requirement a prerequisite for participation in the hospital construction program. The acquisition of qualified personnel to administer State or Territorial plans is of sufficient importance to the successful operation of the entire hospital construction program to warrant the expenditure of Federal funds, to supplement State or Territorial expenditures on a matching basis, and thereby insuring the accomplishment of the objective of this provision. I believe that section 4 should not be adopted. With the exception of the provisions of section 4 of the bills, this Department is in full accord with the objectives of this legislation. The increased Federal appropriations, the extended duration of the program, and the increased Federal share of hospital construction costs which this legislation proposes are in my judgment indispensable to a fuller implementation of the basic objective of the Hospital Survey and Construction Act which is to provide adequate hospital, clinic, and similar services to the people of our Nation. The enctment of this legislation would be of material assistance to the Territories and possessions in meeting their urgent need for additional hospital construction.

In the event that the committee should decide to take favorable action on H. R. 3515, H. R. 2176, and H. R. 3025, I should like to call the committee's attention to, and suggest correction of certain typographical errors in these bills.

H. R. 3515: Page 2, line 6, change "524" to "624"; page 3, line 3, change "623" to "625".

H. R. 2176 and H. R. 3025: Page 2, line 17, change "623" to "625".

In view of your request for an immediate report, this letter is being sent to you prior to its submission to the Bureau of the Budget. Therefore, no commitment can be made, at this time, concerning the relationship of the views expressed herein to the program of the President.

Sincerely yours,

J. A. Krug,
Secretary of the Interior.

Mr. Priest. Our first witness this morning will be Dr. Palmer Dearing, Acting Surgeon General. Dr. Dearing.

STATEMENT OF DR. W. PALMER DEARING, DEPUTY SURGEON GENERAL, UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY; ACCOMPANIED BY DR. VANE M. HOGE, ASSISTANT SURGEON GENERAL, BUREAU OF MEDICAL SERVICE, UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY

Dr. Dearing. Mr. Chairman, with your permission, I should like to introduce Dr. Hoge, the Assistant Surgeon General, who has been responsible for the development of this program, and if there are technical questions and so on, I may wish to ask him to talk to the committee.

Mr. Priest. Very well, Doctor; we will be glad to have both of you.

Dr. Dearing. Mr. Chairman and members of the committee, I appreciate this opportunity to appear before your committee to discuss the proposed amendments to title VI of the Public Health Service Act—the Hospital Survey and Construction Act. A considerable number of bills have been introduced which would amend the act in one or more particulars. First, there is title III of the National Health Insurance and Public Health Act, H. R. 4312 and H. R. 4313; I shall hereafter refer to this as the omnibus bill. Then there are four bills, H. R. 2176, H. R. 2567, H. R. 3025, and H. R. 3515, which are identical with or closely similar to S. 614 on which hearings were held in the Senate. Then there are two bills, H. R. 2175 and H. R. 4126, which would simply increase the Federal share in the cost of projects from the present flat one-third to a flat 50 percent. In addition, H. R. 323 would raise the minimum allotment for any State from $100,000 to $250,000; H. R. 991 would broaden the definition of hospitals to include those furnishing domiciliary care; and H. R. 1721 would simply make hospitals, the construction of which commenced after May 1, 1946, but which otherwise met the requirements of the act, eligible for Federal aid.

Title III of the omnibus bill and H. R. 2176 and the other House bills which are identical with or similar to S. 614, would make a number of substantial changes in title VI. (1) The program would be extended from 1951 as under the present law to 1955 or 1957, that is, an increase of 4 or 6 years; (2) the authorization for appropriation would be increased from the present 75 to 150 million dollars per year beginning with the fiscal year 1950; (3) the amount of Federal participation in the cost of projects would be increased in one way or another over the present uniform 33⅓ percent, the two bills would make different increases and I will discuss this in more detail later; (4) provisions would be added designed to assure that the State agencies will have sufficient funds to administer the program adequately; (5) a new section—identical in both bills—would be added authorizing the Public Health Service itself to conduct, and to make grants for the conduct of, research, experiments, and demonstrations relating to the effective development, utilization, and coordination of hospital services, facilities, and resources; (6) the omnibus bill, but not the other, contains a provision which would make nonprofit group practice facilities eligible for financial aid on the same basis as hospitals.

We are in complete accord with the general objectives of both bills. However, I should like to offer comments on particular provisions.

PRESENT STATUS OF THE PROGRAM

I should like briefly to describe the present status of the program. At present all of the States and Territories have approved State plans and are participating in the program. Thus far, as of the end of May 1949, 792 project applications have received either initial or final approval. The total cost of these projects will be $483,000,000, of which the Federal share will be approximately $149,000,000. Of these projects, 387, with a total cost of $220,000,000, of which the Federal share is $68,000,000, have received final approval, that is contracts have been let and the projects are now being constructed or will be under construction shortly. To date 27 projects have been entirely completed.

There is an inevitable interlude of several months between the time of initial approval of a project and the time when actual construction is ready to begin and the project can be submitted for final approval. After initial approval of a project, which establishes eligibility and earmarks funds for it, the sponsor of the project must then select the site, employ an architect, raise the funds, draw up plans and specifications, and advertise for bids. All of this, we find, takes at least 6 to 8 months. Thus far, as of the end of May, the States have encumbered $55,000,000 of their 1948 allotments and information from the State agencies indicates that, by the end of June, practically all of the $75,000,000 of 1948 allotments will have been encumbered.

Up to the present time about four-fifths of the projects, and about the same proportion of the money, are for the construction of general hospitals. About half of these general hospital projects are sponsored by nonprofit groups and about half are sponsored by public agencies. The majority of the hospitals we are helping to build are small, under 50 beds, are located in small communities, and will serve, in good part, rural people.

The committee may find a somewhat more detailed review of the program helpful in considering the various proposals for amending the act. We have prepared for your later inspection a brief statement, which is submitted as an exhibit and which gives a description of the program, of the needs of the States for additional facilities as shown by the State plans, and of construction projects thus far approved.

You will find this, Mr. Chairman, under tab 3 of the composite.

EXTENSION OF THE PROGRAM AND INCREASE OF FEDERAL ALLOTMENTS

We believe strongly that the provisions of these two bills extending the duration of the program and doubling the annual allotment should be enacted. The present program will hardly do more than scratch the surface of the Nation's needs for additional health facilities. The State plans show that the country as a whole now has 880,000 acceptable beds, exclusive of the approximately 110,000 beds in Federal-civilian hospitals; that is, the United States Public Health Service and the Veterans' Administration hospitals. The State plans estimate that to provide adequate health care to the population an additional 897,000 beds would be needed—this number would be reduced by some 12 percent if account were taken of the beds in Federal hospitals. We estimate that the present 5-year program will help to build somewhere in the neighborhood of 90,000 beds, or approximately 10 percent of the additional beds needed. While there is some construction outside of the program, nevertheless it is obvious that the Nation's needs cannot be met by the program on its present basis. We would therefore favor extension of the program to either 1955 or 1957, preferably the latter, and increase of the Federal allotments from 75 to 150 million dolars.

INCREASED FEDERAL PARTICIPATION

We believe that if the program is to meet its objectives it will be necessary also to increase the Federal share in the cost of projects over and above the present one-third. We have received reports from many of the State agencies to the effect that there are various areas in their States, chiefly low income rural areas, which are unable to take advantage of the present program because they cannot raise their two-thirds of the cost of a hospital. In cooperation with the State agencies we recently made a study of the reason why high priority areas without projects, have not submitted projects. We found that of 307 A priority areas. which have no projects planned or scheduled, approximately one-third were considered by the State agencies to lack the financial ability, even with present Federal aid, to construct and maintain a hospital.

Our data show that whereas the great majority of our projects thus far are located in high priority areas, areas which are largely rural and of low per capita income, nevertheless we are not receiving projects from the very poorest areas. Furthermore, comparisons between the projects financed from 1948 and 1949 allotments indicate that in 1949 our projects will come from areas of lower priority and of somewhat higher per capita income than the projects financed from 1948 allotments. Our data suggest that from now on communities of high priority will tend increasingly to be passed over, because they cannot raise two-thirds of the cost of a hospital, in favor of relatively more prosperous areas with relatively less urgent need.

In determining the precise basis on which the Federal share should be increased we think that certain factors should be held in mind. One of these is that any given amount of Federal money should be made to go as far as possible in building new facilities. The larger the Federal share in the cost of projects the fewer projects that can be aided with a given amount of money. For example, $150,000,000 of

Federal funds with the Federal Government paying two-thirds of the cost of projects will build no more hospitals than $75,000,000 with the Federal Government paying one-third. Therefore, we should hold the Federal share down to the minimum necessary to aid communities in building the facilities they need. Second, we should do nothing to discourage or reduce the incentives for State-aid programs, that is for the State governments to participate in the cost of hospitals. At the present time, 10 States and Territories have effective programs of State aid, under most of these the State bears one-third of the cost of a project, leaving the community to meet only one-third, and several other States have limited programs of State aid or have passed the basic legislation but have not appropriated funds. Third, in increasing the Federal share, the varying financial ability of the States, considered as entities, should be borne in mind. Fourth, we should bear in mind that within each State there are variations in the relative financial ability of communities to construct hospitals, that is there are relatively wealthy communities in poor States and vice versa.

The omnibus bill increases the Federal share in a manner which gives wide discretion to the State agency. It gives the State agency the choice of varying the Federal share among different projects in the State in accordance with objective standards which would take account of differences in financial ability, need, and similar factors; or of deciding that all projects within the State shall receive the same degree of Federal aid. If it elects the first alternative, it may fix the amount of Federal share for the different projects within a range of one-third to two-thirds of the cost. If it elects the second alternative, it may fix the uniform rate of Federal participation within a range of one-third and the State's allotment percentage or 66⅔ percent, whichever is the lower. The State allotment percentages range from 33⅓ to 75 percent, depending on per capita income. And you will find the percentages set forth in appendix A, which would indicate the range within which the State could fix the Federal share, under the second alternative.

H. R. 2176 and the similar House bills contain a different formula. They would fix the Federal share for each State at that State's allotment percentage. This percentage would be uniform for all projects in a State and the State agency would have no discretion to lower the Federal share below the State's allotment percentage.

We believe that the formula provided in the omnibus bill is the more satisfactory one. We think that the provisions of H. R. 2176, because of the high percentage of Federal aid for certain States, will tend to discourage State aid and result in the building of too few projects. We also think it is desirable to give the States considerable discretion in the use of their Federal allotments. If the general approach of H. R. 2176 is adopted, we should suggest that it be revised so as to allow States to set the Federal share for all projects at a percentage lower than their allotment percentage, if they so desire.

ADMINISTRATIVE EXPENSES OF STATE AGENCIES

The present program places heavy responsibilities upon the State agencies. They must annually survey and inventory their existing hospital facilities and redraw their hospital-construction programs in the light of experience and to take account of new construction.

They must be prepared to offer counsel and guidance to communities as to the facilities they need. They must carefully determine the priority of areas; they must approve plans and specifications for projects and inspect construction in progress. The value of the whole program will depend in very large measure upon the competency and adequacy of State administration. It is, therefore, of the highest importance that the State agencies should have sufficient funds for their administrative expenses.

The two groups of bills approach this problem in different ways. The omnibus bill would provide Federal aid to the States for administration. It provides for the annual allotment of slightly more than $1,000,000 to the States on essentially the same basis as the funds for construction. These allotments are available to the States on a 50–50 matching basis. We believe that aid to the States for their administrative expenses is necessary and that the provisions of this bill are sound. Accordingly, we favor their enactment.

H. R. 2176 and the similar House bills use a different approach. In effect they provide for the withdrawal of Federal aid for construction if the Surgeon General finds that the State is not appropriating adequate funds for administration for its program. Adequate funds are defined as $15,000, or 2 percent—in one bill 1 percent—of the total amount to be expended under the State program. We would not favor enactment of this provision. We believe that the penalty is too severe and that, more important, it will be impossible to devise any formula which will determine automatically the amount that each State will need for administration. Inevitably the amount so determined will be more than is needed in some cases, less than is needed in others.

STUDIES AND DEMONSTRATIONS

Both the omnibus bill and H. R. 2176 contain an identical section, page 63 of the omnibus bill, which authorizes the Surgeon General to conduct research, experiments, and demonstrations relating to the effective development and utilization of hospital services, facilities, and resources and, after consultation with the Federal Hospital Council, to make grants-in-aid to States, political subdivisions, universities, hospitals, and other public or private nonprofit organizations for projects for the conduct of research, experiments, or demonstrations relating to the development, utilization, and coordination of hospital services, facilities, and resources. Any grants for such projects may be made for as long as a 5-year period with a proviso that the total obligation for grants payable in any fiscal year may not exceed $1,200,000.

This section would make explicit the authority of the Public Health Service to conduct research and studies relating to hospital services and facilities. Such studies, we believe, are necessary to the effective and intelligent operation of the hospital-construction program. However, the chief value of this section, in our eyes, is that it would give us a small amount of funds with which to make grants to demonstrate the value of, and to stimulate and encourage programs of, regional coordination of hospital services.

It has become obvious that the public cannot secure good hospital service unless there is coordination among hospitals on a regional basis. The 25- or 50- or 100-bed hospital of a small town, and the professional personnel which provides service in this hosiptal, cannot hope as a separate independent unit to provide a complete or adequate service. For example, the small hospital of 50 beds cannot hope to have a full-time radiologist or a full-time pathologist. However, radiology and pathology service can be made available in such a hospital through regular visits by a radiologist and pathologist from a large hospital of the region, and through consultative and cooperative arrangement for the provisions of these services between the two institutions. Similarly, the average hospital of 50 or 75 beds cannot hope to have an intern or resident. Yet the presence in such a hospital of a house physician would be of great benefit to the patient, and the need of setting up procedures for the training of an intern or resident would be of great value to the physicians forming the staff of the hospital. In teaching the intern or resident they themselves would learn much. But while a small hospital by itself cannot hope to have these advantages, it could secure these benefits through coordination with the teaching hospital or medical center of the region. In other words, the teaching hospital might assign an intern or resident to the smaller hospital on a rotating basis, sending one man for 3 months and then another man for 3 months, and so forth. If this arrangement is to work well and the intern or resident is to receive proper training it will be necessary for staff members of the parent or teaching hospital to visit the smaller hospital periodically, to make rounds with the intern or resident, and to hold clinical conferences in which the medical staff of the smaller hospital will participate. Such an arrangement can be of great benefit to the smaller hospital and its patients; it can give the intern or resident a type of training which he would not otherwise secure; and it can broaden and improve the skills of the physicians of the community and help them to become better physicians. An incidental benefit of the arrangement is that it may increase the supply of doctors in smal towns and rural areas since physicians often set up their practices in the communities in which they have interned.

Another beneficial activity which could be developed through coordination would be the holding of periodic clinical conferences in the small hospitals. The larger institutions of the region would make it possible for consultants periodically to visit the smaller hospitals on the request of the staff and to lead discussions on medical subjects selected by the staff.

Through the formation of a regional hospital council many activities can be developed which would be of great assistance to all of the hospitals and their professional staffs, particularly the smaller ones. Thus postgraduate or continuation courses can be developed for physicians, dentists, and nurses. Training programs can be developed for X-ray and laboratory technicians. The technicians from a small hospital can be brought into the teaching hospital for a month's training, while the latter hospital sends substitute technicians to the smaller hospital. Periodic meetings of the administrators and trustees of the various hospitals can be arranged for discussion of common problems.

We think that through the development of coordination of this sort among the hospitals of a region great improvement in medical care can be made, that it is in fact only through such arrangements that we can hope to provide good medical service to the people of small towns and rural localities. The aim of these arrangements is not at all to drain patients from the periphery into the center, but rather the reverse—to build up the periphery, to make it less necessary for patients to be referred to the big city. For years various factors have tended to draw physicians into the big cities and to dry up medical service at the crossroads. Regional coordination is a means of reversing this tendency.

With the aid of funds from some of the well-known foundations a few experimental programs of regional coordination have been placed in operation. There is, for example, the Council of Rochester Regional Hospitals in Rochester, N. Y., developed with the aid of the Commonwealth Fund; the New England Medical Center program aided by the Bingham Associates Fund; the program developed in Virginia by the Medical College of Virginia with the aid of the Commonwealth Fund, and the Michigan program developed with the aid of the Kellogg Foundation.

If this section of the proposed amendments is enacted we would have a relatively small amount of money annually with which to make grants to State agencies, regional councils, medical schools, teaching hospitals, so as to establish a few more of these experimental and demonstration programs. We think it would be money extremely well spent.

EFFECTIVE DATE

Section 312 (c), page 64, of the omnibus bill provides that the increased Federal participation in the cost of projects shall be retroactive to the beginning of the program—August 13, 1946. Section 7 of H. R. 2176 and the other identical House bills provide that the increased Federal share would be applied to all projects approved on and after January 1, 1949. The Public Health Service questions the wisdom of the retroactive features of these bills. These features would introduce a new principle in Federal grant-in-aid procedures. The objective of increasing the rate of Federal participation is to give greater encouragement and inducement to the States and communities to construct more needed hospitals. That objective is not furthered by a retroactive provision applying the increased Federal share to construction to which the States and communities are already committed.

On behalf of the limited retroactivity provided for in H. R. 2176 that is back to January 1, 1949, it may be argued that it is necessary, or at least expedient, in order to avoid the danger of having applicants postpone their construction projects until the enactment of the new bill. However, it would not seem necessary to go as far back as January 1 for this purpose and, in any case, no such argument can be made for a provision which is retroactive to August 13, 1946, and we strongly oppose this provision in the omnibus bill.

TECHNICAL AMENDMENTS

In addition to the amendments discussed above there are a number of technical points on which our experience indicates that revision of the act would be desirable. The principal points falling within this category are the following: (*a*) increase of the minimum allotment from $100,000 to $200,000 in accordance with the increase in the allotment base from $75,000,000 to $150,000,000; (*b*) liberalization of the present strict requirement that an application for Federal assistance have sole title to the site of the proposed hospital; (*c*) relaxation of the present law's requirements that an application be filed by only one agency and that the hospital when completed be owned and operated by the agency filing the application; (*d*) amendment of the provision for recovery by the United States in the event that the hospital ceases to be nonprofit in character so as to avoid the implication that the Federal Government secures a lien on the hospital through extending aid for its construction; (*e*) provision for payment of the Federal share of the cost of construction direct to the applicant at the request of the State agency; and (*f*) incorporation into the basic act of the provisions of the 1948 and 1949 Appropriation Acts which (1) simplified the provisions for determining the total amount available for allotment to States for construction, and (2) provided that the Federal share of the cost of construction of each approved project shall be a contractual obligation of the Federal Government.

These amendments have been incorporated in the omnibus bill. Their adoption would cause some change in the wording, though none in the substance, of the other bills. They are discussed in more detail in the attached statement entitled "Technical Amendments to the Hospital Survey and Construction Act."

SUMMARY

In summary, gentlemen, we believe that these legislative proposals, modified along the lines I have indicated, will mark another important step forward in the effort to achieve a high level of health for the people of this country.

(The technical amendments referred to are as follows:)

TECHNICAL AMENDMENTS TO THE HOSPITAL SURVEY AND CONSTRUCTION ACT

In addition to the amendments of major importance already discussed, this Agency believes that the act should be revised with respect to a number of other points. These proposed revisions are technical and clarifying in nature. It is believed that, if adopted, they will be of material assistance in facilitating administration of the program. They cover the following subjects:

1. Increase of the minimum allotment provided under section 624.
2. Liberalization of the requirement that title to the site of a proposed hospital be vested "solely" in the applicant.
3. Liberalizing and clarification of the requirements for filing applications.
4. Clarification of the provisions as to the purposes for which Federal grants may be used.
5. Provision that at the request of the State agency payment of the Federal share of construction payments may be made direct to the applicant.
6. Amendment of the provision for recovery by the United States Government in the event that the hospital ceases to be nonprofit in character to avoid implication that the Federal Government secures a lien on the hospital.
7. Incorporation into the basic act of provisions of appropriation acts with respect to allotment base, authorization of appropriation, and contractual obligation.

More detailed comments on these points follow:

1. *Increase of the minimum allotment.*—This Agency favors the increase of the minimum allotment which any State may receive from the present figure of $100,000 to at least $200,000. If the percentage of Federal participation is to be increased as provided in S. 614 or in the manner suggested in our previous

testimony, a corresponding increase in each State's allotment will be necessary so that the program for the State will permit Federal participation in the same number of projects. Furthermore, we believe that the present minimum is too low, even on the basis of Federal participation of 33⅓ percent to give a State adequate assistance for the development of a program of hospital construction. The cost of hospital construction is currently estimated conservatively at not less than $12,000 a bed. At this rate, allotment of $100,000 to a State will finance at the most eight beds per annum. Under the standards established in the act and the Surgeon General's regulations, this will provide hospitalization for less than 2,000, or, taking into account State and local funds, 6,000 persons. Such an allotment is too small to permit development of an adequate hospital plan, and we believe that it should be substantially increased.

2. *Vesting of hospital title "solely" in the applicant.*—In its present form section 625 (a) (3) of the act requires, as a condition precedent to approval of an application, reasonable asurance that title to the site of the proposed hospital "is or will be vested solely in the applicant." This is a very strict requirement, excluding the possibility of an interest in any person other than the applicant. It would prevent the applicant from building a hospital on land in which it has an interest, such as a 99-year lease, which is accepted as the equivalent of fee simple title by the community generally. Moreover, the insistence on full legal title in the applicant necessitates frequent consideration of technical legal questions as to the existence of title in situations involving mineral rights, reversionary rights, restrictive covenants, and other types of interests. It is believed that this requirement goes beyond what is necessary to safeguard the interests of the Federal Government. As a practical matter. we believe that the purposes of the Federal act would be satisfied if the applicant has an interest in the site sufficient to enable it to build a hospital thereon and operate the hospital for a substantial period of time.

We therefore favor an amendment which would give the Surgeon General some discretion as to the types of interest which he would accept as sufficient to support an application on the general principle that the interest must be sufficient to assure undisturbed use and possession for a period of not less than 50 years for construction and operation of a hospital. Such a principle would be consistent with the approach which has been adopted in the selection of sites for Federal buildings and in other Federal construction rograms. Examples are section 207 (a) of the National Housing Act (12 U. S. C. A. 1707 (a)) and regulations thereunder, and section 9 of the Federal Airport Act (Public Law 377, 79th Cong.; 49 U. S. C. A. 1108 (d)).

3. *Requirements for filing applications.*—The restrictive wording employed in section 625 (a) of the act, which contains requirements for filing of applications and their review by the Surgeon General, has resulted in some difficulties of administration. The section in its present form apparently does not permit more than one applicant to join in the filing of an application. Furthermore, it requires as a condition of approval assurances that "the applicant" will conform to certain operating requirements such as the nondiscrimination requirement and conformance with State standards of maintenance and operation. This has created complications in cases where the facility is to be operated by some institution or agency other than the party which has undertaken the responsibility for its construction and has applied for Federal participation. It will frequently be true, for example, that a community will build a hospital and entrust its operation to some outside agency with experience in hospital management. In such a case, the question is presented whether the applicant can give assurances that it will conform to State standards of maintenance and operation or the nondiscrimination requirements of the State plan, since the actual operation of the hospital will be the responsibility of another agency. Another situation where the language of the section creates difficulty is that in which two governmental units such as a town and a city will join in the building or operation of a hospital or health center. In such a case it is obviously necessary that the two be empowered to join for purposes for the same application.

We believe that these situations are proper instances for the extension of Federal assistance under the program contemplated under the act. We accordingly recommend that the act be amended to permit two or more persons to join in the filing of an application and also to permit the assurances as to the operation of the hospital under the act to be fulfilled by someone other than the applicant. For the same reason we recommend that the definition of "nonprofit hospital" in section 631 (g) of the act be amended to make it clear that it includes a hospital which is owned by one nonprofit institution and operated by another.

At the present the law does not require the applicant to designate any payee to whom the Federal share may be paid over. We believe this requirement should be made, particularly if more than one agency signs the application.

In addition, we believe that in the interests of clarity the provisions of section 625 (a) should be regrouped and renumbered. This would involve minor changes of phraseology but no substantial amendments.

4. *Purposes for which Federal grants may be used.*—Section 625 (d) in its present form requires that funds paid out in the course of construction grants be used solely for carrying out approved projects. Inasmuch as payments under the act are actually made on a reimbursement basis, we suggest that the subsection be amended to include reimbursement for expenditures in carrying out the project as a permissible use of funds granted under the act.

5. *Payment of Federal share direct to applicant.*—Section 625 (b) of the act requires that funds granted for construction payments be paid by the Federal Government to the State and be paid by the State to the applicant. The only exception is that, where State law prohibits the State agency from making payment to the applicant, the Federal Government may make payment direct. A number of State agencies have suggested the advisability of making payments directly from the Federal Government to the applicant in all cases. It is pointed out that, at least in some cases, processing of the money by the State agency serves no useful purpose and will result in a considerable delay in the money coming to the applicant. Accordingly, it is recommended that the section be amended to provide for payment direct to the applicant when the State agency so requests, whether or not the State agency is legally prohibited from making payments to the applicant. It should be emphasized that this is purely a technical amendment concerned solely with the handling of the funds. It is not intended to derogate in any way from the responsibility of the State agency for approval of applications and certifying installment payments on the basis of inspection.

6. *Recovery of Federal funds under certain contingencies.*—Section 625 (e) of the act provides that in case a hospital which has been constructed wholly or partly with Federal assistance under the act ceases to be a nonprofit hospital, or where it is transferred to a person who would not authorized to file an application under the act (i. e., where the transferee is not a public or other nonprofit hospital, the Federal Government may recover one-third the then value of the hospital from the transferor or the transferee. This provision has created difficulties for nonprofit institutions seeking to obtain part of the non-Federal share of the cost of construction through mortgage loans from banks, insurance companies, and other lending agencies. The lending agencies have in several cases taken the position that this provision either created a prior lien in the Federal Government or at least impaired the mortgage security of the lender to a substantial degree. While it is believed that the provision does not create a lien in the Federal Government but merely gives the Government a personal right of action against the transferor or the transferee, it must be conceded that the value of the motgage security is impaired to some extent by the provision. This is true because any purchaser at a foreclosure sale might incur a potential liability to the Federal Government.

We believe this objection from the standpoint of the lending agency may be eliminated by deleting the reference to liability of the transferee. Our experience indicates that, unless such an amendment is adopted nonprofit institutions will not be able to obtain mortgage financing to assist in meeting the non-Federal part of the cost of their projects. It is, of course, a question of policy for the Congress to decide whether or not to permit mortgage loans in the case of a federally aided project. The increase in the Federal share provided by the proposed amendment would lessen the general need for such financing; although in several States the increase would be slight. In view of the general acceptance of mortgage loans as a means of financing hospital construction and the frequent inquiries we have had on the point, we believe this amendment deserves the committee's careful consideration.

We also believe that a number of other technical amendments to the subsection are desirable. The change in the percentage of Federal participation necessitates revision of the provision that the amount of the Federal recovery be one-third the then value of the hospital. The section also should be amended to clarify the fact that the Federal Government could collect no more than the amount of Federal participation. In addition, we believe that the subsection should provide that, in the case of involuntary transfers, such as mortgage foreclosures, the amount of Federal recovery would be measured against the actual proceeds of the transferor rather than against the value of the hospital at the time. If the property were sold under court order to satisfy a mortgage lien or other indebtedness, the Government would then have a claim only in the event the hospital mortgagor had an equity in excess of the indebedtedness. We also favor adding a provision to require a State agency before approving a transferee to obtain from the transferee all the assurances relating to maintenance and operation of the hospital required of the original applicant.

7. *Authorization of appropriation and contractual obligation.*—The provisions for determination of the total amount to be allotted to States for construction in a fiscal year are extremely complicated and have proven unworkable in the actual administration of the program. When the law was enacted, Congress provided for an annual allotment to each State, representing the total amount of Federal assistance to be extended to hospitals in the State for the year for which the allotment was made. A State would be entitled to an allotment for a year if it had a State plan of hospital construction approved by the Surgeon General under the act prior to or during such year. The amount of the allotment was the State's proportionate share (determined according to a formula in section 624) of the amount authorized to be appropriated for the year. The amount authorized to be appropriated annually was fixed at the base amount of $75,000,000, but elaborate cumulative provisions were included under which the amount was to be increased on the occurrence of certain contingencies. Thus, if Congress should fail to appropriate the total amount authorized for the year or if a State should not have a plan approved prior to or during a year, or if it should not use up the full amount of its allotment, the amount authorized to be appropriated (and therefore the allotment base) for the succeeding year would be increased proportionately. This system was designed for the purpose of enabling the States to know with at least approximate accuracy upon enactment of the bill the amounts of their respective basic allotments for each of the 5 years of the programs (Senate committee report, p. 12). The cumulative provisions were intended to insure that the program would make available to the States the full amount of five annual allotments of $75,000,000 each.

This system was founded on the assumption that Congress would appropriate annually the full amounts authorized to be appropriated. In practice, however, this has not been found necessary. Under the law, no Federal funds are paid out until construction actually begins on a project. Before this can occur, a State plan must be approved, and projects for the construction of hospitals in accordance with the State plan must have been approved both by the State agency and the Surgeon General. No State plans at all were approved during the fiscal year 1947, the first year of the program, and approval of projects based on the State plans did not occur in substantial numbers until the fiscal year 1948 was well advanced. As a result, there were no Federal payments at all for construction during 1947, and payments in the fiscal year 1948 were only a very small fraction of the amount authorized to be appropriated for that year. The Appropriations Committees of Congress were unwilling to appropriate funds which would not be needed for a considerable time in the future, but did not wish to delay the development of the program by withholding allotments from the States. Accordingly, they hit on the device of not appropriating the full amount authorized but made provision in annual appropriation acts for allotments totaling $75,000,000 annually. For greater assurance to applicants, it was also provided that the Federal share of the cost of construction of projects approved by the Surgeon General would constitute a contractual obligation of the United States. The amounts actually appropriated were limited to sums considered necessary for the liquidation of contractual obligations during the year.

This system has proven completely satisfactory in practice, and this Agency recommends that it be enacted into law on a permanent basis. It seems highly unlikely that the system contemplated in the act as originally passed will ever be put into effect. Indeed, because of the discrepancy between appropriations and allotments, the adoption of this practice would result in allotments over the 5-year period aggregating considerably more than the $375,000,000 originally envisaged by the Congress as the total Federal participation for the entire program. Unless, therefore, Congress wishes to continue on the present basis and include provisions in the appropriation act each year defining the scope of the program, it is evident that the basic act should be revised. This Agency believes that there are obvious disadvantages of the practice of including what is in effect substantive legislation in successive appropriation acts, and that it would be desirable from the standpoint of both the States and the Federal Government to revise the present act to include the substance of the annual appropriation acts. Accordingly, it is recommended that the act be amended to provide an annual allotment base of a flat amount; if the amount suggested in S. 614 is adopted, this base would be $150,000,000 a year. The cumulative provisions of the act are believed to be no longer necessary and should be discarded. The contractual obligation provision would be incorporated into the act and the authorization for appropriation would be changed to authorize the appropriation annually of such sums as are necessary to liquidate contractual obligations. This would have the advantage of permitting the appropriation of more than $75,000,000 in any 1 year after the accumulation of obligations renders this necessary.

This suggestion does not entail any change in the administration of the act. It would serve merely to eliminate what is believed to be an undesirable conflict between the basic act and annual appropriation acts and would incorporate into permanent statutory form the provisions which Congress has adopted annually and which have proven completely satisfactory in actual administration.

REVIEW OF THE HOSPITAL SURVEY AND CONSTRUCTION PROGRAM

The Hospital Survey and Construction Act, which became law on August 13, 1946, has two main purposes: first, to assist the States in surveying their needs for hospitals and health centers and in developing programs for the construction of the facilities of this type required for adequate health care of the population; and, second, to aid in the construction of hospitals and health centers in accordance with these programs.

PROVISIONS OF THE ACT

To assist the States in their surveys and in the development of construction plans, Congress authorized an appropriation of $3,000,000 to be allotted among the States on a population basis, with the proviso that no State would be allotted less than $10,000. These funds could be drawn upon to pay one-third of the State's expenditures for surveys and planning.

The act also authorizes an appropriation of $75,000,000 each year for 5 years (ending June 30, 1951) to aid in the construction of hospitals, health centers, and related facilities. These funds are allotted among the States according to a formula based on population and per capita income which gives considerably larger amounts per capita to low- than to high-income States. (Appendix A shows the allotments of the individual States.) One-third of the construction costs of approved projects may be met from these allotments, with the balance supplied by non-Federal funds. To be eligible for allotments, a State must submit a State plan for construction and have it approved.

One of the main requirements for approval is that the State plan designate a single State agency to administer or supervise administration of the plan and provide for the designation of a State advisory council. The plan must set forth a hospital construction program based on the State-wide inventory of hospitals and survey of need. Further, the plan must provide for construction, insofar as financial resources permit, in the order of relative need; provide appropriate methods of administration; and provide minimum standards (to be fixed at the discretion of the State) for the maintenance and operation of the hospitals constructed under the program.

Federal administration of the program is the responsibility of the Surgeon General of the Public Health Service, who consults with the Federal Hospital Council of eight members. Four of these are experts in hospital and health fields, and four represent the consumers of hospital services.

Both hospitals and public health centers may be built under the act. The hospitals may be either public or private nonprofit institutions. They may be general, tuberculosis, mental, chronic disease, or other types, except those furnishing primarily room and board rather than treatment. Laboratories, outpatient departments, nurses' homes and training facilities, and central service units related to the hospital may also be built. Public health centers are defined as publicly owned facilities for the provision of public health services, the scope of which is a matter for State and local determination. Related facilities such as laboratories, clinics, and administrative offices are also authorized.

The term "construction" is broadly defined to include construction of new buildings; expansion, remodeling, and alteration of existing buildings; and initial equipment for any such new or existing facilities.

To receive Federal funds for a project, the public or nonprofit sponsor applies through the State agency to the Public Health Service. The application must contain plans and specifications for the proposed facility, assurance of financial support for construction and for maintenance of the facility when completed. The applicant must also give assurance that the facility will provide service without discrimination as to race, creed, or color and will furnish a reasonable volume of free patient care.

SURVEYS AND PLANNING

Congress appropriated $1,800,000 for allotment to the States for surveys and planning. All of the States and Territories, with the exception of Delaware, the District of Columbia, and the Virgin Islands, have taken advantage of this Federal aid. As of April 30, 1949, $1,126,777 had been paid out to the States for these purposes. Eleven States and two Territories have utilized in full their available allotments.

THE STATE PLANS

The State plans for hospital construction include the inventories of existing hospital and health-center facilities, the determinations of need for additional facilities, and the construction program. To date, all of the States and Territories except Nevada have submitted plans which have been approved by the Surgeon General. These State plans, taken together, probably provide the most authoritative statement thus far available of the Nation's supply of acceptable hospital, health-center, and related facilities and of the additional facilities and beds which are needed for the provision of adequate hospital care to the entire population. (Appendix B shows for each State the number of existing beds and additional beds needed, by type of hospital.)

General hospitals.—The States have planned the building of general hospitals within the pattern set by the act and the regulations drawn up by the Surgeon General and the Federal Hospital Council. The act specifies the ratios of beds to population beyond which the Federal Government will not match State or local funds; these limits are 4.5 beds per 1,000 population in States having 12 or more persons per square mile; 5.0 in States having more than 6 and fewer than 12 persons per square mile; and 5.5 in States having 6 or fewer persons per square mile. The regulations instruct the States to divide their areas into main hospital service regions with subordinate areas in each, setting a pattern for a coordinated hospital system. Three types of areas are designated: base, intermediate, and rural.

The State plans (as of December 31, 1948) show that 474,539 general hospital beds (exclusive of those in Federal hospitals) are in existence. Of these, 397,168 are considered by the State agencies to be acceptable, while 77,371 have been declared nonacceptable because of unsuitable design, fire hazards, health hazards, etc. To meet their total needs as determined by the States, 255,443 more general hospital beds are needed. No State, according to the plans which have been submitted, has enough acceptable beds to meet the standards established under the act.

Some 2,300 general hospital service areas have been outlined in the various State plans. Of these areas, about one-fourth—containing nearly 10,000,000 persons—are reported to be without any existing acceptable general hospital beds. As might be expected, the majority of these areas are designated as "rural" in the State plans.

The relatively richer areas shown in the State plans are better supplied with hospital beds than are the poorer areas. For example, areas with per capita incomes of less than 50 percent of the average for their State have only one-third of the total beds which they need. On the other hand, areas with per capita incomes equal to or above the average for the State have about two-thirds of the total beds needed.

As mentioned previously, each State plan must set up a priority system for general hospital projects. As would be expected, the high-priority areas are, in general, more rural and have a lower per capita income than the low-priority areas.

Mental, tuberculosis, and chronic-disease hospitals.—Planning for mental, tuberculosis, and chronic-disease hospitals is usually on a State-wide basis. The over-all State ratios beyond which the Federal Government will not match funds are the following: (*a*) For tuberculosis patients, 2.5 times the average annual deaths from tuberculosis in the State during the 5-year period 1940–44; (*b*) for mental patients, 5 beds per 1,000 population; (*c*) for chronic-disease patients, 2 beds per 1,000 population.

The State plans indicate that considerable thought has been given to the problem of constructing mental and tuberculosis beds as units of, or in conjunction with, general hospitals for the diagnosis and treatment of the early stages of these illnesses. In the chronic-disease category the State plans show that construction plans are very limited in scope or completely lacking. In general, the State agencies have indicated that further study of the chronic-disease problem is necessary before it is possible to develop a sound chronic-disease hospital program.

The State plans report the following data on total existing beds, existing acceptable beds, and additional beds needed in the mental, tuberculosis, and chronic-disease categories:

	Total existing beds	Existing acceptable beds	Additional beds needed
Mental	428, 931	381, 627	310, 523
Tuberculosis	154, 836	72, 215	82, 886
Chronic disease	36, 250	28, 517	248, 294

Public health centers and related facilities.—According to the act, Federal aid may not be given for construction of public health centers throughout a State in excess of 1 such center per 30,000 population, or in States having less than 12 persons per square mile, 1 per 20,000 population. No limit is placed upon the number of related facilities which may be constructed with Federal aid.

The State plans indicate that the Nation has has 468 public health centers and needs an additional 1,853. Eight States and the Virgin Islands report no existing acceptable health centers, and only Rhode Island and Alaska indicate that their present number is adequate. With respect to related facilities, 36 States and Territories report 723 existing facilities of this type and a need for 1,386 additional facilities. The plans of the remaining 16 States and Territories do not include any data on related facilities.

Summary.—Slightly more than 1,000,000 beds of all types are in existence today, according to the State surveys of existing facilities. Of these, approximately 145,000 have been classified as nonacceptable, leaving 880,000 beds which are considered acceptable. On the basis of the ratios prescribed in the act, State plans show that the Nation needs approximately 900,000 additional hospital beds, distributed as follows: general beds, 28 percent; mental, 35 percent; tuberculosis, 9 percent; chronic disease, 28 percent. Although the largest number of beds needed is in the mental category, the need is relatively greatest in the chronic-disease category, where acceptable beds constitute only 10 percent of the total needed.

CONSTRUCTION PROGRESS

The present law has been in effect for 2¾ years. As was anticipated at the start of the program, the first year was devoted to the conduct of the State surveys of existing facilities and to the preparation of State plans for the construction of additional facilities. Consequently, no construction funds were requested or made available by Congress during the first fiscal year of the program.

Over the past year and 9 months since the first State allotment for construction was made available, the number of approved construction applications has steadily and rapidly increased. In September of 1947 the first project application received the Surgeon General's approval. Within the next 6 months—by April 30, 1948—the number of approved applications had increased to a total of 249, with total construction costs estimated at $123,000,000. By the end of April 1949 a total of 768 project applications had received approval. These projects will have a total cost of $469,100,000, of which the Federal share will amount to $145,000,000. Final approval has been given to 336 of the 768 projects; that is, funds have been raised, sites acquired, plans and specifications approved, and contracts have been let. The value of these projects now under contract is $185,000,000, involving $60,000,000 of Federal funds.

Type of project

Of the 768 projects approved as of April 30, 1949, 591 are general hospitals, with 29,087 beds; 39 are mental hospitals, with 4,527 beds; 28 are tuberculosis hospitals, with 2,809 beds; 12 are chronic-disease hospitals, with 1,023 beds; and 98 are public health centers. The total beds of all types number 37,446. As shown by these figures, the States have centered their efforts until now on the construction of general-hospital projects. About four-fifths of all approved projects, beds to be constructed, and total construction costs are accounted for by general hospital projects. (Appendix C gives data on approved projects by State.)

General-hospital projects

Among the various States and Territories all but the District of Columbia, Hawaii, and the Virgin Islands have submitted and received approval for one or more general-hospital projects. Three out of every five (a total of 360) of the general-hospital-project applications are for completely new facilities; the remaining two out of five are for additions or alterations to existing hospitals.

For the most part the new general facilities are of relatively small size; the 360 new general-hospital projects average about 49 beds. Nearly 60 percent of the projects are for hospitals with less than 50 beds, and only 13 percent are for facilities with 100 or more beds.

At the beginning of the program many observers felt that the metropolitan centers probably would obtain most of the Federal funds. The reverse, however, is true. Of the 591 general-hospital projects (including those for new facilities and for alterations or additions to existing facilities) 308, or more than half, are in communities of less than 5,000 persons; of these, 187 are in towns or villages of less than 2,500 persons. Only 86 projects are in cities of over 25,000 population, and, of these, nearly all (68) are for additions or alterations rather than for new facilities.

A slightly higher proportion of the general-hospital projects are sponsored by public rather than by voluntary nonprofit organizations; 44 percent of the projects are for publicly owned facilities, compared with 56 percent for voluntary nonprofit facilities. Inasmuch as nonprofit general hospitals thus far approved tend to be somewhat larger than those sponsored by governmental units, the total beds to be constructed are about evenly divided between nonprofit and governmental facilities. In terms of construction costs, nonprofit facilities account for slightly more than half of the estimated costs of all general hospital projects.

APPENDIX A

Allotments for hospital construction and State allotment percentages, fiscal years 1948 and 1949 (Public Law 725, 79th Cong., Hospital Survey and Construction Act, as amended)

State or Territory	Allotments		State allotment percentages, 1948–49
	1948	1949	
Total United States and Territories	$75,000,000	$75,000,000	--------
Alabama	2,885,880	2,690,543	70.22
Alaska	[1] 100,000	[1] 100,000	50.00
Arizona	451,739	443,109	59.78
Arkansas	1,966,582	1,966,552	73.07
California	1,956,160	2,121,367	33.51
Colorado	656,652	635,878	53.73
Connecticut	421,523	422,222	33.33
Delaware	[1] 100,000	[1] 100,000	38.13
District of Columbia	298,110	275,268	40.75
Florida	1,460,260	1,481,446	57.49
Georgia	2,976,228	2,791,307	67.97
Hawaii	222,758	261,868	50.00
Idaho	293,162	300,347	54.51
Illinois	2,768,690	2,764,357	41.35
Indiana	1,726,355	1,754,093	48.74
Iowa	1,340,446	1,393,932	52.86
Kansas	932,719	972,758	51.23
Kentucky	2,587,095	2,560,957	69.17
Louisiana	2,154,850	2,099,507	65.47
Maine	454,438	467,139	52.36
Maryland	869,663	827,301	44.82
Massachusetts	1,593,795	1,622,561	42.64
Michigan	2,169,996	2,174,668	43.14
Minnesota	1,653,926	1,725,122	55.70
Mississippi	$2,401,451	$2,270,043	75.00
Missouri	2,280,213	2,293,924	55.25
Montana	231,530	224,137	48.84
Nebraska	684,394	682,443	52.54
Nevada	(2)	[1] 100,000	41.24
New Hampshire	342,122	367,648	59.80
New Jersey	1,312,554	1,328,053	38.61
New Mexico	457,062	457,632	65.92
New York	2,941,663	3,029,743	33.33
North Carolina	3,429,016	3,413,486	69.24
North Dakota	308,157	287,845	52.57
Ohio	2,690,189	2,715,846	42.87
Oklahoma	1,639,006	1,730,437	62.72
Oregon	460,361	534,815	42.40
Pennsylvania	4,547,379	4,692,355	48.15
Puerto Rico	2,460,083	2,327,387	75.00
Rhode Island	279,966	267,856	43.21
South Carolina	1,974,755	1,923,581	71.56
South Dakota	359,217	353,873	56.39
Tennessee	2,671,070	2,616,055	66.30
Texas	4,836,567	4,865,137	59.64
Utah	364,840	354,023	53.60
Vermont	214,510	227,131	56.77
Virginia	2,208,159	2,114,928	60.52
Virgin Islands	32,765	29,271	75.00
Washington	511,646	553,979	34.94
West Virginia	1,554,281	1,529,058	64.96
Wisconsin	1,621,161	1,610,133	50.75
Wyoming	144,856	146,879	53.66

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[1] Minimum allotments of $100,000 as specified in Public Law 725, 79th Cong., as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong.

[2] Excluded because no plan was submitted as of June 30, 1948, in accordance with the opinion of the Comptroller General, dated Aug. 24, 1948.

APPENDIX B

TABLE I.—*Existing beds, net additional and total beds needed (reported in official State plans for hospital construction, as of Jan. 1, 1949* [1]*)*

ALL HOSPITAL BEDS [2]

State	Civilian population [3]	Total beds needed [4]	Existing beds		Additional beds needed
			Total	Acceptable [5]	
Total United States and Territories [6]	139,686,549	1,776,187	1,024,840	879,527	897,146
Total United States [6]	137,007,330	1,732,061	1,008,957	867,851	864,696
Alabama	2,728,120	34,832	12,881	11,134	23,698
Arizona	648,195	9,724	4,748	4,410	5,314
Arkansas	1,877,409	23,956	10,592	6,847	17,109
California	9,605,000	112,208	74,284	61,833	50,375
Colorado	1,060,239	14,676	11,429	10,378	4,298
Connecticut	2,016,000	24,810	16,240	16,056	8,983
Delaware	293,000	3,780	2,856	2,744	1,036
District of Columbia	815,195	10,865	10,765	5,900	4,965
Florida	2,248,595	28,043	14,115	13,377	14,666
Georgia	3,088,393	38,811	19,061	18,607	20,204
Idaho	472,314	6,141	2,558	2,094	4,047
Illinois	7,548,109	95,207	55,199	41,264	53,943
Indiana	3,387,463	42,098	19,958	16,682	25,416
Iowa	2,539,075	30,273	15,996	10,474	19,799
Kansas	1,794,559	21,833	10,985	10,353	11,480
Kentucky	2,520,537	34,007	15,197	14,361	19,646
Louisiana	2,468,596	32,334	16,231	12,639	19,695
Maine	874,038	10,788	7,587	6,208	4,580
Maryland	1,983,697	26,457	18,593	17,249	9,208
Massachusetts	4,566,800	60,271	45,237	43,712	16,559
Michigan	6,049,897	74,556	38,927	26,216	48,340
Minnesota	2,817,972	35,592	21,369	18,418	17,195
Mississippi	1,990,073	25,340	9,915	8,336	17,004
Missouri	3,776,250	48,795	29,090	28,113	20,682
Montana	492,240	6,878	4,928	4,351	2,527
Nebraska	1,275,713	15,944	11,867	10,496	5,448
New Hampshire	497,812	6,275	4,576	4,300	1,975
New Jersey	4,217,108	53,729	36,481	36,456	17,273
New Mexico	535,220	7,693	2,698	2,552	5,141
New York	13,847,903	174,881	138,212	125,235	49,646
North Carolina	3,572,631	45,989	22,095	19,439	26,550
North Dakota	519,709	7,324	4,919	4,829	2,510
Ohio	7,498,400	93,388	43,970	38,134	55,254
Oklahoma	2,034,460	26,609	14,507	14,096	12,513
Oregon	1,452,618	17,519	9,328	8,677	8,842
Pennsylvania	10,004,220	125,388	71,819	60,591	64,797
Rhode Island	735,344	9,171	7,084	6,954	2,217
South Carolina	1,883,106	23,764	9,162	8,621	15,143
South Dakota	544,866	7,417	4,698	4,253	3,164
Tennessee	2,832,480	38,130	15,087	14,912	23,218
Texas	7,004,100	89,352	36,404	34,761	54,591
Utah	591,910	7,267	3,458	3,220	4,047
Vermont	364,000	4,486	3,420	3,027	1,651
Virginia	2,810,278	36,152	18,339	11,581	24,571
Washington	1,953,725	24,309	19,903	16,509	7,829
West Virginia	1,732,355	22,014	10,902	7,893	14,121
Wisconsin	3,162,606	39,440	29,401	17,871	21,569
Wyoming	275,000	3,545	1,886	1,688	1,857
Total Territories	2,679,219	44,126	15,883	11,676	32,450
Alaska	87,631	2,034	630	287	1,747
Hawaii	523,802	6,686	4,518	1,912	4,774
Puerto Rico	2,038,628	35,038	10,385	9,477	25,561
Virgin Islands	29,158	368	350	----------	368

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands, prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes general, mental, tuberculosis, and chronic hospital beds.

[3] Total civilian population as reported in the State plans.

[4] Total beds needed as calculated on the basis of ratios prescribed by the act; total beds needed does not equal sum of existing acceptable plus additional needs in those States where existing beds exceed the number allowable on the basis of the State ratios.

[5] Number of existing beds which are reported as "acceptable"; excludes beds classified as "nonacceptable" by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[6] Excludes Nevada, which has not submitted a plan.

TABLE II.—*Existing beds, net additional and total beds needed (reported in official State plans for hospital construction, as of Jan. 1, 1949*[1]*)*

GENERAL BEDS[2]

State	Total beds needed[3]	Existing beds			Additional beds needed
		Total	Acceptable[4]		
			Number	Per 1,000 population	
Total, United States and Territories[5]	652, 611	474, 539	397, 168	2. 8	255, 443
Total, United States[5]	640, 455	464, 493	390, 412	2. 8	250, 043
Alabama	12, 277	6, 573	4, 886	1. 8	7, 391
Arizona	3, 627	2, 831	2, 557	3. 9	1, 070
Arkansas	8, 484	4, 445	3, 290	1. 8	5, 194
California	44, 236	32, 810	27, 858	2. 9	16, 378
Colorado	5, 552	4, 860	4, 093	3. 9	1, 459
Connecticut	9, 206	6, 774	6, 590	3. 3	2, 616
Delaware	1, 414	1, 173	1, 161	4. 0	253
District of Columbia	3, 668	4, 112	2, 111	2. 6	1, 557
Florida	10, 123	6, 762	6, 570	2. 9	3, 553
Georgia	13, 898	7, 337	6, 883	2. 2	7, 015
Idaho	2, 598	1, 619	1, 155	2. 4	1, 443
Illinois	34, 662	27, 952	22, 955	3. 0	11, 707
Indiana	15, 333	9, 714	7, 203	2. 1	8, 130
Iowa	11, 520	9, 119	6, 689	2. 6	4, 831
Kansas	8, 272	5, 741	5, 109	2. 8	3, 163
Kentucky	11, 788	6, 232	5, 745	2. 3	6, 043
Louisiana	11, 779	8, 495	7, 110	2. 9	4, 669
Maine	3, 933	3, 035	1, 656	1. 9	2, 277
Maryland	9, 154	6, 736	6, 515	3. 3	2, 639
Massachusetts	23, 887	19, 341	17, 906	3. 9	5, 981
Michigan	27, 780	18, 119	14, 011	2. 3	13, 769
Minnesota	14, 028	11, 403	9, 165	3. 3	4, 863
Mississippi	8, 977	4, 829	3, 345	1. 7	5, 632
Missouri	18, 276	14. 319	13, 342	3. 5	4, 934
Montana	3, 043	2, 893	2, 316	4. 7	727
Nebraska	6, 512	5, 457	4, 086	3. 2	2, 426
New Hampshire	2, 374	2, 204	1, 928	3. 9	446
New Jersey	20, 620	16, 675	16, 650	3. 9	3, 970
New Mexico	3, 010	1, 356	1, 210	2. 3	1, 800
New York	62, 716	56, 942	43, 965	3. 2	18, 751
North Carolina	17, 491	9, 798	8, 003	2. 2	9, 488
North Dakota	3, 427	2, 376	2, 286	4. 4	1, 141
Ohio	33, 792	21, 635	19, 110	2. 5	14, 682
Oklahoma	9, 877	7, 389	6, 978	3. 4	2, 899
Oregon	6, 619	4, 453	3, 886	2. 7	2, 733
Pennsylvania	45, 019	35, 375	27, 268	2. 7	17, 751
Rhode Island	3, 310	1, 981	1, 851	2. 5	1, 459
South Carolina	8, 628	4, 785	4, 244	2. 3	4, 384
South Dakota	3, 151	2, 618	2, 173	4. 0	978
Tennessee	13, 061	6, 890	6, 715	2. 4	6, 346
Texas	31, 936	18, 678	17, 158	2. 4	14, 778
Utah	2, 959	2, 242	2, 004	3. 4	955
Vermont	1, 638	1, 261	868	2. 4	770
Virginia	12, 745	7, 594	6, 813	2. 4	5, 932
Washington	9, 166	7, 890	7, 398	3. 8	1, 768
West Virginia	7, 979	6, 329	4, 671	2. 7	3, 308
Wisconsin	15, 400	12, 243	10, 026	3. 2	5, 374
Wyoming	1, 510	1, 098	900	3. 3	610
Total, Territories	12, 156	10, 046	6, 756	2. 5	5, 400
Alaska	489	449	127	1. 4	362
Hawaii	2, 357	2, 547	784	1. 5	1, 573
Puerto Rico	9, 174	6, 753	5, 845	2. 9	3, 329
Virgin Islands	136	297	---------	---------	136

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., August 13, 1946, as amended by Public Law 723, June 19, 1948 and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals planned for the care and treatment of acute conditions and specialized types of cases.

[3] Total beds needed as calculated on the basis of ratios prescribed by the act.

[4] Number of existing beds which are reported as acceptable; excludes beds classified as nonacceptable by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[5] Excludes Nevada, which has not submitted a plan.

TABLE III.—*Existing beds, net additional and total beds needed (reported in official State plans for hospital construction, as of Jan. 1, 1949* [1]*)*

MENTAL BEDS [2]

State	Total beds needed [3]	Existing beds			Additional beds needed
		Total	Acceptable [4]		
			Number	Per 1,000 population	
Total United States and Territories [5]	[6] 691, 958	428, 931	381, 627	2. 7	310, 523
Total United States [5]	[6] 678, 573	426, 773	379, 620	2. 8	299, 145
Alabama	13, 641	5, 729	5, 729	2. 1	7, 912
Arizona	3, 245	1, 250	1, 250	1. 9	1, 995
Arkansas	9, 387	4, 796	2, 206	1. 2	7, 181
California	41, 696	29, 408	28, 310	2. 9	13, 386
Colorado	5, 300	5, 268	5, 204	4. 9	96
Connecticut	10, 080	7, 280	7, 280	3. 6	2, 800
Delaware	1, 465	1, 254	1, 154	3. 9	311
District of Columbia	4, 076	5, 161	2, 567	3. 1	1, 509
Florida	11, 243	5, 842	5, 842	2. 6	5, 401
Georgia	15, 440	9, 351	9, 351	3. 0	6, 089
Idaho	2, 361	721	721	1. 5	1, 640
Illinois	37, 741	22, 289	13, 351	1. 8	24, 390
Indiana	16, 937	8, 386	8, 264	2. 4	8, 673
Iowa	12, 695	6, 086	3, 113	1. 2	9, 582
Kansas	8, 965	4, 786	4, 786	2. 7	4, 179
Kentucky	12, 603	7, 135	7, 052	2. 8	5, 551
Louisiana	12, 343	6, 796	4, 620	1. 9	7, 723
Maine	4, 370	3, 586	3, 856	4. 4	514
Maryland	10, 090	7, 453	7, 278	3. 7	2, 812
Massachusetts	22, 840	21, 123	21, 102	4. 6	1, 738
Michigan	30, 250	15, 171	7, 522	1. 2	22, 728
Minnesota	14, 090	7, 644	7, 185	2. 5	6, 905
Mississippi	9, 950	4, 408	4, 408	2. 2	5, 542
Missouri	18, 880	11, 885	11, 885	3. 1	6, 995
Montana	2, 384	1, 800	1, 800	3. 7	584
Nebraska	6, 378	6, 210	6, 210	4. 9	168
New Hampshire	2, 565	1, 985	1, 985	4. 0	580
New Jersey	21, 085	14, 145	14, 145	3. 4	6, 940
New Mexico	2, 676	1, 018	1, 018	1. 9	1, 658
New York	69, 239	64, 511	64, 511	4. 7	4, 728
North Carolina	17, 863	10, 123	9, 446	2. 6	8, 418
North Dakota	2, 598	2, 160	2, 160	4. 2	438
Ohio	37, 495	18, 428	16, 239	2. 2	21, 256
Oklahoma	10, 172	5, 932	5, 932	2. 9	4, 240
Oregon	7, 263	4, 299	4, 299	3. 0	2, 964
Pennsylvania	50, 021	29, 555	28, 818	2. 9	21, 203
Rhode Island	3, 677	3, 282	3, 282	4. 5	395
South Carolina	9, 415	3, 414	3, 414	1. 8	6, 001
South Dakota	2, 724	1, 888	1, 888	3. 5	836
Tennessee	14, 162	6, 808	6, 808	2. 4	7, 356
Texas	34, 797	13, 631	13, 631	1. 9	21, 16
Utah	2, 959	1, 120	1, 120	1. 9	1, 839
Vermont	[6] 1, 820	2, 012	2, 012	5. 5	----------
Virginia	14, 050	9, 234	3, 848	1. 4	10, 202
Washington	9, 769	5, 077	4, 341	2. 2	5, 428
West Virginia	8, 585	3, 252	2, 201	1. 3	6, 384
Wisconsin	15, 813	13, 105	5, 770	1. 8	10, 043
Wyoming	1, 375	706	706	2. 6	669
Total, Territories	13, 385	2, 158	2, 007	. 7	11, 378
Alaska	438	----------	----------	----------	438
Hawaii	2, 620	809	689	1. 3	1, 931
Puerto Rico	10, 193	1, 318	1, 318	. 6	8, 875
Virgin Islands	134	31	----------	----------	134

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals for the diagnosis and treatment of nervous and mental illness but excludes beds in institutions for the feeble-minded and epileptics.

[3] Total beds needed as calculated on the basis of five beds per thousand population.

[4] Number of existing beds which are reported as acceptable; excludes beds classified as nonacceptable to the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[5] Excludes Nevada, which has not submitted a plan.

[6] Total beds needed does not equal the sum of existing acceptable plus additional needed in Vermont, where existing beds exceed the number allowable on the basis of the State ratio.

TABLE IV.—*Existing beds, net additional and total beds needed (reported in official State plans for hospital construction, as of Jan. 1, 1949* [1]*)*

TUBERCULOSIS BEDS [2]

State	Average annual TB deaths 1940–44 [3]	Total beds needed [4]	Existing beds			Additional beds needed
			Total	Acceptable [5]		
				Number	Per death	
Total United States and Territories [6]	62,072.0	154,836	85,120	72,215	1.16	82,886
Total United States [6]	56,778.8	141,605	81,659	69,406	1.22	72,464
Alabama	1,383.2	3,458	579	519	.38	2,939
Arizona	621.0	1,554	559	559	.90	995
Arkansas	932.0	2,330	1,351	1,351	1.45	979
California	3,839.2	9,598	6,784	2,231	.58	7,367
Colorado	399.2	1,704	1,270	1,050	2.63	654
Connecticut	597.0	[7] 1,492	1,721	1,721	2.88	----------
Delaware	126.0	315	193	193	1.53	122
District of Columbia	596.4	1,491	1,177	1,052	1.76	439
Florida	872.0	2,180	1,018	515	.59	1,665
Georgia	1,318.8	3,297	1,288	1,288	.98	2,009
Idaho	94.8	237	55	55	.58	182
Illinois	3,083.2	7,708	4,570	4,570	1.48	3,138
Indiana	1,221.0	3,053	1,779	1,136	.93	1,917
Iowa	392.0	980	791	672	1.71	308
Kansas	404.0	1,010	458	458	1.13	552
Kentucky	1,830.0	4,575	1,607	1,564	.85	3,011
Louisiana	1,310.0	3,275	940	909	.69	2,366
Maine	295.0	737	526	526	1.78	211
Maryland	1,271.0	3,177	1,883	1,743	1.37	1,434
Massachusetts	1,763.2	4,408	3,673	3,604	2.04	804
Michigan	1,770.4	4,426	4,645	3,811	2.15	615
Minnesota	735.0	[7] 1,838	1,924	1,859	2.53	----------
Mississippi	973.2	2,433	541	458	.47	1,975
Missouri	1,635.0	4,087	1,805	1,805	1.10	2,282
Montana	199.0	497	235	235	1.18	262
Nebraska	201.0	503	200	200	1.00	303
New Hampshire	124.0	310	189	189	1.52	121
New Jersey	1,856.0	3,590	3,359	3,359	1.81	231
New Mexico	374.8	937	284	284	.76	653
New York	6,092.0	15,230	11,594	11,594	1.90	3,636
North Carolina	1,396.0	3,490	2,014	1,830	1.31	1,660
North Dakota	104.0	[7] 260	275	275	2.64	----------
Ohio	2,841.0	7,103	3,298	2,785	.98	4,318
Oklahoma	996.4	2,491	1,186	1,186	1.19	1,305
Oregon	292.6	732	576	492	1.68	240
Pennsylvania	4,136.0	10,340	5,647	3,609	.87	6,731
Rhode Island	285.0	713	629	629	2.21	84
South Carolina	782.0	1,955	903	903	1.15	1,052
South Dakota	181.2	453	192	192	10.6	261
Tennessee	2,096.8	5,242	1,142	1,142	.54	4,100
Texas	3,480.0	8,700	2,124	2,103	.60	6,597
Utah	66.0	165	96	96	1.45	69
Vermont	120.0	300	147	17	1.23	153
Virginia	1,494.8	3,737	1,511	920	.62	2,817
Washington	586.4	1,466	1,317	833	1.42	633
West Virginia	806.4	2,016	1,321	1,021	1.27	995
Wisconsin	760.8	1,902	2,201	1,651	2.17	251
Wyoming	44.0	110	82	82	1.86	28
Total, Territories	5,293.2	13,231	3,461	2,809	.53	10,422
Alaska	373.0	932	137	116	.31	816
Hawaii	265.0	661	1,048	439	1.66	222
Puerto Rico	4,637.2	11,593	2,254	2,254	.49	9,339
Virgin Islands	18.0	45	22	----------	----------	45

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals for the diagnosis and treatment of tuberculosis, excluding preventoria.

[3] Average annual deaths from tuberculosis over the 5-year period from 1940 to 1944, inclusive, as reported in the State plans.

[4] Total beds needed as calculated on the basis of a ratio of 2.5 beds per average annual deaths from tuberculosis.

[5] Number of existing beds which are reported as "acceptable"; excluded beds classified as "nonacceptable" by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[6] Excludes Nevada, which has not submitted a plan.

[7] Total beds needed does not equal the sum of existing acceptable plus additional needed in Connecticut, Minnesota, and North Dakota, where existing beds exceed the number allowable on the basis of the State ratio.

TABLE V.—*Existing beds, net additional and total beds needed (reporte in official State plans for hospital construction, as of Jan. 1, 1949* [1]*)*

CHRONIC BEDS [2]

State	Total beds needed [3]	Existing beds			Additional beds needed
		Total	Acceptable [4]		
			Number	Per 1,000 population	
Total United States and Territories [5]	[6] 276, 782	36, 250	28, 517	0. 20	248, 294
Total United States [5]	[6] 271, 428	36, 032	28, 413	. 21	243, 044
Alabama	5, 456	--------	--------	--------	5, 456
Arizona	1, 298	108	44	. 07	1, 254
Arkansas	3, 755	--------	--------	--------	3, 755
California	16, 678	5, 282	3, 434	. 36	13, 244
Colorado	2, 120	31	31	. 03	2, 089
Connecticut	4, 032	465	465	--------	3, 567
Delaware	586	236	236	. 81	350
District of Columbia	1, 630	315	170	. 21	1, 460
Florida	4, 497	493	450	. 20	4, 047
Georgia	6, 176	1, 085	1, 085	. 35	5, 091
Idaho	945	163	163	. 35	782
Illinois	15, 096	388	388	. 05	14, 708
Indiana	6, 775	79	79	. 02	6, 696
Iowa	5, 078	--------	--------	--------	5, 078
Kansas	3, 586	--------	--------	--------	3, 586
Kentucky	5, 041	223	--------	--------	5, 041
Louisiana	4, 937	--------	--------	--------	4, 937
Maine	1, 748	170	170	. 19	1, 578
Maryland	4, 036	2, 521	1, 713	. 86	2, 323
Massachusetts	9, 136	1, 100	1, 100	. 24	8, 036
Michigan	12, 100	992	872	. 14	11, 228
Minnesota	5, 636	398	209	. 07	5, 427
Mississippi	3. 980	137	125	. 06	3, 855
Missouri	7, 552	1, 081	1, 081	. 29	6, 471
Montana	954	--------	--------	--------	954
Nebraska	2, 551	--------	--------	--------	2, 551
New Hampshire	1, 026	198	198	. 40	828
New Jersey	8, 434	2, 302	2, 302	. 55	6, 132
New Mexico	1, 070	40	40	. 07	1, 030
New York	27, 696	5, 165	5, 165	. 37	22, 531
North Carolina	7, 145	160	160	. 04	6, 985
North Dakota	1, 039	108	108	. 21	931
Ohio	14, 998	609	--------	--------	14, 998
Oklahoma	4, 069	--------	--------	--------	4, 069
Oregon	2, 905	--------	--------	--------	2, 905
Pennsylvania	20, 008	1, 242	896	. 09	19, 112
Rhode Island	1, 471	1, 192	1, 192	1. 62	279
South Carolina	3, 766	60	60	. 03	3, 706
South Dakota	1, 089	--------	--------	--------	1, 089
Tennessee	5, 665	247	247	. 09	5, 418
Texas	13, 919	1, 971	1, 869	. 27	12, 050
Utah	1, 184	--------	--------	--------	1, 184
Vermont	728	--------	--------	--------	728
Virginia	5, 620	--------	--------	--------	5, 620
Washington	[6] 3, 908	5, 619	3, 937	2. 02	--------
West Virginia	3, 434	--------	--------	--------	3, 434
Wisconsin	6, 325	1, 852	424	. 13	5, 901
Wyoming	550	--------	--------	--------	550
Total Territories	5, 354	218	104	. 04	5, 250
Alaska	175	44	44	. 50	131
Hawaii	1, 048	114	--------	--------	1, 048
Puerto Rico	4, 078	60	60	. 03	4, 018
Virgin Islands	53	--------	--------	--------	53

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excludes Nevada, which has not submitted a plan.

[2] Includes beds in hospitals, the primary purpose of which is medical treatment of chronic illness, including the degenerative diseases, and which furnishes hospital treatment and care; excludes tuberculosis and mental hospitals, nursing homes, and also institutions, the primary purpose of which is domiciliary care.

[3] Total beds needed as calculated on the basis of 2.0 beds per thousand population.

[4] Number of existing beds which are reported as "acceptable"; excludes beds classified as "nonacceptable" by the State agencies on the basis of fire hazards, obsolete construction, health hazards, etc.

[5] Excludes Nevada, which has not submitted a plan.

[6] Total beds needed does not equal the sum of existing acceptable plus additional needed in Washington, where existing beds exceed the number allowable on the basis of the State ratio.

TABLE VI.—*Number of existing and programed health centers and auxiliary facilities (reported in official State plans for hospital construction, as of Jan. 1, 1949* [1]*)*

State	Health centers [2]			Auxiliary facilities [3]		
	Total	Existing	Programed	Total	Existing	Programed
Total United States and Territories	2,321	468	1,853	2,108	722	1,386
Total United States	2,226	426	1,800	2,066	695	1,371
Alabama	67	35	32	12	2	10
Arizona	9	3	6	16	1	15
Arkansas	77	5	72	--------	--------	--------
California	160	33	127	121	55	66
Colorado	16	2	14	32	--------	32
Connecticut	62	31	31	--------	--------	--------
Delaware	5	--------	5	--------	--------	--------
Dist. of columbia	6	1	5	--------	--------	--------
Florida	39	3	36	164	16	148
Georgia	57	12	45	128	12	116
Idaho	6	2	4	17	--------	17
Illinois	253	1	252	--------	--------	--------
Indiana	37	1	36	--------	--------	--------
Iowa	27	1	26	--------	--------	--------
Kansas	49	16	33	--------	--------	--------
Kentucky	22	8	14	104	88	16
Louisiana	49	--------	49	52	--------	52
Maine	25	--------	25	--------	--------	--------
Maryland	33	18	15	114	113	1
Massachusetts	41	11	30	2	1	1
Michigan	79	45	34	17	17	--------
Minnesota	11	1	10	2	--------	2
Mississippi	72	19	53	173	14	159
Missouri	41	11	30	--------	--------	--------
Montana	13	1	12	1	--------	1
Nebraska	23	2	21	6	4	2
New Hampshire	--------	--------	--------	--------	--------	--------
New Jersey	42	--------	42	--------	--------	--------
New Mexico	10	9	1	32	13	19
New York	188	30	158	288	288	--------
North Carolina	101	12	89	14	--------	14
North Dakota	8	2	6	--------	--------	--------
Ohio	37	--------	37	58	--------	58
Oklahoma	68	7	61	18	2	16
Oregon	18	12	6	7	3	4
Pennsylvania	46	22	24	--------	--------	--------
Rhode Island	7	7	--------	--------	--------	--------
South Carolina	46	8	38	236	5	231
South Dakota	11	--------	11	--------	--------	--------
Tennessee	94	12	82	111	34	77
Texas	80	14	66	150	9	141
Utah	16	2	14	2	1	1
Vermont	5	--------	5	13	--------	13
Virginia	78	15	63	13	3	10
Washington	20	7	13	54	13	41
West Virginia	22	3	19	60	--------	60
Wisconsin	44	1	43	45	1	44
Wyoming	6	1	5	4	--------	4
Total, Territories	95	42	53	42	27	15
Alaska	15	15	--------	2	2	--------
Hawaii	11	3	8	33	22	11
Puerto Rico	68	24	44	3	3	--------
Virgin Islands	1	--------	1	4	--------	4

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[1] State plans for 47 States, District of Columbia, Alaska, Puerto Rico, and the Virgin Islands prepared under the Hospital Survey and Construction Act, Public Law 725, 79th Cong., Aug. 13, 1946, as amended by Public Law 723, June 19, 1948, and Public Law 830, June 29, 1948, 80th Cong. Excluding Nevada, which has not submitted a plan.

[2] Number of publicly owned facilities utilized by a local health unit for the provision of public healt services.

[3] Number of publicly owned auxiliary facilities such as laboratories or clinics physically separated from the administrative offices of the local health unit.

APPENDIX C

TABLE I.—*Number of projects, number of beds provided, total estimated construction costs, and Federal share, by State (as of Apr. 30, 1949)*

State	Number of projects	Number of beds	Construction costs	
			Total	Federal share
Total	768	37, 446	$468, 981, 030	$145, 436, 491
Alabama	20	1, 375	19, 586, 509	6, 363, 504
Arizona	5	265	3, 126, 804	726, 340
Arkansas	18	1, 039	8, 374, 688	2, 775, 546
California	21	733	12, 650, 870	4, 018. 960
Colorado	7	323	4, 091, 691	1, 352, 227
Connecticut	6	211	2, 419, 980	789, 993
Delaware	1	40	607. 601	202, 353
Florida	16	1, 280	14, 536, 962	4, 615, 509
Georgia	34	964	12, 290, 170	4, 082, 778
Idaho	5	203	2, 393, 988	665, 496
Illinois	13	854	14, 588, 564	4, 681, 799
Indiana	20	923	13, 594, 038	4, 362, 390
Iowa	17	564	7, 684, 087	2, 216, 031
Kansas	16	479	6, 154, 931	1, 907, 764
Kentucky	30	1, 339	15, 040, 162	4, 974, 578
Louisiana	22	1, 204	13, 853, 426	4, 283, 137
Maine	4	198	2, 194, 211	716, 841
Maryland	5	327	4, 724, 171	1, 488, 777
Massachusetts	12	536	9, 252, 425	2, 743, 118
Michigan	15	1, 007	15, 861, 778	5, 259, 659
Minnesota	17	664	9, 247, 344	3, 067, 448
Mississippi	67	1, 968	21, 529, 155	6, 990, 749
Missouri	8	573	9, 977, 837	3, 308, 728
Montana	6	128	1, 298, 107	420, 712
Nebraska	16	337	5, 102, 552	1, 099, 370
New Hampshire	2	52	1, 176, 780	392, 260
New Jersey	9	966	12, 687, 449	3, 089, 844
New Mexico	8	432	4, 730, 836	959, 341
New York	38	1, 955	28, 900, 266	8, 195, 903
North Carolina	34	2, 172	22, 447, 606	7, 076, 449
North Dakota	5	100	1, 223, 980	407, 391
Ohio	21	1, 219	18, 021, 738	5, 230, 770
Oklahoma	30	836	8, 599, 370	2, 823, 715
Oregon	5	151	2, 028, 480	671, 584
Pennsylvania	23	1, 780	25, 753, 705	8, 315, 685
Rhode Island	5	230	3, 114, 500	971, 333
South Carolina	49	893	9, 488, 401	3, 109, 136
South Dakota	7	191	1, 679, 468	549, 765
Tennessee	21	1, 323	15, 405, 609	5, 075, 567
Texas	53	3, 045	30, 496, 109	8, 689, 195
Utah	6	179	1, 991, 255	656, 082
Vermont	4	165	2, 232, 173	688, 487
Virginia	15	694	12, 242, 520	3, 876, 449
Washington	11	244	3, 592, 023	1, 146, 832
West Virginia	3	341	6, 960, 775	2, 315, 257
Wisconsin	9	605	7, 616, 975	2, 462, 263
Wyoming	2	52	586, 723	192, 240
Alaska	1	34	599, 076	199, 692
Hawaii	1	216	2, 472, 525	383, 720
Puerto Rico	5	2, 037	14, 751, 177	4, 843, 724

TABLE II.—*Distribution of approved project applications from each State, by type of facility (as of Apr. 30, 1949)*

State	Total projects	Type of facility				
		General	P. H. C.	Mental	TB	Chronic
Total	768	591	98	39	28	12
Alabama	20	15	3	1	1	
Arizona	5	5				
Arkansas	18	12		5	1	
California	21	21				
Colorado	7	7				
Connecticut	6	5	1			
Delaware	1	1				
Florida	16	12	1	1	1	1
Georgia	34	18	15			1
Idaho	5	5				
Illinois	13	12			1	
Indiana	20	17	1	1	1	
Iowa	17	17				
Kansas	16	16				
Kentucky	30	22		2	6	
Louisiana	22	11	7	3	1	
Maine	4	3				1
Maryland	5	3	1	1		
Massachusetts	12	9	1			2
Michigan	15	15				
Minnesota	17	12	2	1		2
Mississippi	67	41	25		1	
Missouri	8	8				
Montana	6	6				
Nebraska	16	16				
New Hampshire	2	2				
New Jersey	9	5		3		1
New Mexico	8	8				
New York	38	37				1
North Carolina	34	22		6	5	1
North Dakota	5	5				
Ohio	21	20			1	
Oklahoma	30	24	2	3	1	
Oregon	5	4		1		
Pennsylvania	23	23				
Rhode Island	5	5				
South Carolina	49	13	28	7	1	
South Dakota	7	7				
Tennessee	21	14	3	1	3	
Texas	53	47	2	1	2	1
Utah	6	5	1			
Vermont	4	4				
Virginia	15	11	4			
Washington	11	9	1			1
West Virginia	3	3				
Wisconsin	9	8		1		
Wyoming	2	2				
Alaska	1	1				
Hawaii	1				1	
Puerto Rico	5	3		1	1	

TABLE III–A.—*General hospitals: Distribution of approved project applications, beds, total construction costs, and Federal share by State (as of Apr. 30, 1949)*

State	Number of projects	Number of beds	Construction costs	
			Total	Federal share
Total	591	29,087	$382,486,861	$120,207,265
Alabama	15	1,301	17,431,492	5,660,166
Arizona	5	265	3,126,804	726,340
Arkansas	12	539	5,232,452	1,728,126
California	21	733	12,650,870	4,018,960
Colorado	7	323	4,091,691	1,352,227
Connecticut	5	211	2,416,980	788,993
Delaware	1	40	607,061	202,353
Florida	12	760	9,183,818	2,849,647
Georgia	18	914	10,683,319	3,547,167
Idaho	5	203	2,393,988	665,496
Illinois	12	754	13,231,133	4,235,107
Indiana	17	755	11,856,052	3,788,019
Iowa	17	564	7,684,087	2,216,031
Kansas	16	479	6,154,931	1,907,764
Kentucky	22	1,043	10,826,503	3,575,613
Louisiana	11	604	7,282,028	2,228,540
Maine	3	167	2,021,751	673,916
Maryland	3	254	3,107,900	1,020,466
Massachusetts	9	416	6,873,690	2,150,621
Michigan	15	1,007	15,861,778	5,259,659
Minnesota	12	376	4,930,570	1,638,371
Mississippi	41	1,814	18,056,054	5,846,030
Missouri	8	573	9,977,837	3,308,728
Montana	6	128	1,298,107	420,712
Nebraska	16	337	5,102,552	1,099,370
New Hampshire	2	52	1,176,780	392,260
New Jersey	5	367	4,880,992	1,598,708
New Mexico	8	432	4,730,836	959,341
New York	37	1,955	28,509,930	8,065,791
North Carolina	22	1,535	18,998,626	5,950,549
North Dakota	5	100	1,223,980	407,391
Ohio	20	1,135	17,233,713	5,138,940
Oklahoma	24	721	7,007,202	2,294,445
Oregon	4	151	1,983,480	656,584
Pennsylvania	23	1,780	25,752,705	8,315,685
Rhode Island	5	230	3,114,500	971,333
South Carolina	13	590	6,470,566	2,108,234
South Dakota	7	191	1,679,468	549,765
Tennessee	14	835	8,465,981	2,762,359
Texas	47	2,084	22,901,602	7,459,393
Utah	5	179	1,927,515	634,836
Vermont	4	165	2,232,173	688,487
Virginia	11	694	11,967,065	3,784,715
Washington	9	194	3,244,105	1,034,860
West Virginia	3	341	6,960,775	2,315,257
Wisconsin	8	365	4,689,620	1,536,312
Wyoming	2	52	586,723	192,240
Alaska	1	34	599,076	199,692
Puerto Rico	3	345	4,065,000	1,281,666

NOTE.—Project applications include those for new building construction, alterations, additions, and replacements. The number of beds shown above are those provided in new facilities or in additions to existing facilities.

TABLE III-B.—*Mental hospitals: Distribution of project applications, beds, total construction costs, and Federal share, by States (as of Apr. 30, 1949)*

State	Number of projects	Number of beds	Construction costs	
			Total	Federal share
Totals	39	4,527	$33,798,159	$10,920,791
Alabama	1	20	135,000	45,000
Arkansas	5	400	2,347,047	782,357
Florida	1	40	448,361	131,103
Indiana	1	125	1,032,075	344,025
Kentucky	2	232	2,944,519	977,589
Louisiana	3	500	5,016,914	1,672,303
Maryland	1	73	1,515,831	434,831
Minnesota	1	60	1,108,060	369,353
New Jersey	3	475	2,890,857	927,806
North Carolina	6	487	2,339,144	779,643
Oklahoma	3	85	1,393,500	464,500
Oregon	1	----------	45,000	15,000
South Carolina	7	160	1,099,241	366,412
Tennessee	1	188	1,243,830	414,610
Texas	1	550	2,000,000	500,000
Wisconsin	1	240	2,927,355	925,951
Puerto Rico	1	892	5,310,925	1,770,308

TABLE III-C.—*Tuberculosis hospitals: Distribution of project applications, beds, total construction costs, and Federal share, by State (as of Apr. 30, 1949)*

State	Number of projects	Number of beds	Construction costs	
			Total	Federal share
Total	28	2,809	$27,499,240	$8,338,254
Alabama	1	54	635,000	200,000
Arkansas	1	100	795,189	265,063
Florida	1	400	3,659,683	1,219,894
Illinois	1	100	1,357,431	446,692
Indiana	1	43	687,650	227,716
Kentucky	6	64	1,269,140	421,376
Louisiana	1	100	1,038,254	214,219
Mississippi	1	154	1,875,000	625,000
North Carolina	5	110	588,776	196,257
Ohio	1	84	788,025	91,830
Oklahoma	1	30	112,500	37,500
South Carolina	1	143	600,000	200,000
Tennessee	3	300	5,587,308	1,862,435
Texas	2	111	657,507	154,802
Hawaii	1	216	2,472,525	383,720
Puerto Rico	1	800	5,375,252	1,791,750

NOTE.—Project applications include those for new building construction, alterations, additions, and replacements. The number of beds shown above are those provided in new facilities or in additions to existing facilities.

Only those States are shown from which applications for the specified type of project have been received.

TABLE III-D.—*Chronic disease hospitals: Distribution of project applications, beds, total construction costs, and Federal share, by State (as of Apr. 30, 1949)*

State	Number of projects	Number of beds	Construction costs	
			Total	Federal share
Totals	12	1,023	$16,070,815	$2,964,644
Florida	1	80	759,600	253,199
Georgia	1	50	363,600	121,200
Maine	1	31	172,460	42,925
Massachusetts	2	120	1,881,240	426,666
Minnesota	2	228	2,051,991	680,236
New Jersey	1	124	4,915,600	563,330
New York	1	----------	390,336	130,112
North Carolina	1	40	521,060	150,000
Texas	1	300	4,712,000	500,000
Washington	1	50	302,928	96,976

TABLE III–E.—*Public health centers: Distribution of project applications, beds, total construction costs, and Federal share, by State (as of Apr. 30, 1949)*

State	Number of projects	Construction costs	
		Total	Federal share
Total	98	$9,125,955	$3,005,537
Alabama	3	1,385,017	458,338
Connecticut	1	3,000	1,000
Florida	1	485,000	161,666
Georgia	15	1,243,251	414,411
Indiana	1	18,261	2,630
Louisiana	7	516,230	168,075
Maryland	1	100,440	33,480
Massachusetts	1	497,495	165,831
Minnesota	2	1,156,723	379,488
Mississippi	25	1,598,101	519,719
Oklahoma	2	86,168	27,270
South Carolina	28	1,318,594	434,490
Tennessee	3	108,490	36,163
Texas	2	225,000	75,000
Utah	1	63,740	21,246
Virginia	4	275,455	91,734
Washington	1	44,990	14,996

NOTE.—Project applications include those for new building construction, alterations, additions, and replacements. The number of beds shown above are those provided in new facilities or in additions to existing facilities. Only those States are shown from which applications for the specified type of project have been received.

TABLE IV.—*Distribution of all[1] general hospital projects in each State by size of community (as of Apr. 30, 1949)*

State	Number of projects	Size of community					
		Under 2,500	2,500 to 4,999	5,000 to 9,999	10,000 to 24,999	25,000 to 49,999	50,000 and over
Totals	591	187	121	106	91	25	61
Alabama	15	4	3	--------	--------	1	7
Arizona	5	1	--------	2	--------	1	1
Arkansas	12	--------	8	4	--------	--------	--------
California	21	12	6	2	1	--------	--------
Colorado	7	2	3	1	1	--------	--------
Connecticut	5	1	1	1	2	--------	--------
Delaware	1	--------	--------	1	--------	--------	--------
Florida	12	1	4	1	3	1	2
Georgia	18	5	2	3	4	--------	4
Idaho	5	2	2	1	--------	--------	--------
Illinois	12	1	5	3	3	--------	--------
Indiana	17	4	4	4	3	1	1
Iowa	17	5	7	4	--------	--------	1
Kansas	16	7	5	2	2	--------	--------
Kentucky	22	8	3	2	3	1	5
Louisiana	11	1	3	2	3	1	1
Maine	3	--------	--------	--------	1	1	1
Maryland	3	2	--------	--------	--------	1	--------
Massachusetts	9	--------	--------	2	5	--------	2
Michigan	15	1	1	8	3	--------	2
Minnesota	12	9	2	1	--------	--------	--------
Mississippi	41	22	9	4	6	--------	--------
Missouri	8	1	2	3	1	--------	1
Montana	6	4	2	--------	--------	--------	--------
Nebraska	16	11	4	--------	1	--------	--------
New Hampshire	2	1	1	--------	--------	--------	--------
New Jersey	5	2	--------	2	--------	1	--------
New Mexico	8	2	1	3	2	--------	--------
New York	37	3	6	3	12	2	11
North Carolina	22	11	7	2	2	--------	--------
North Dakota	5	5	--------	--------	--------	--------	--------
Ohio	20	--------	3	10	5	2	--------
Oklahoma	24	5	5	4	5	1	4
Oregon	4	2	2	--------	--------	--------	--------
Pennsylvania	23	1	2	8	6	2	4
Rhode Island	5	--------	--------	--------	--------	4	1
South Carolina	13	4	1	5	2	1	--------
South Dakota	7	7	--------	--------	--------	--------	--------

[1] See footnote at end of table.

TABLE IV.—*Distribution of all*[1] *general hospital projects in each State by size of community (as of Apr. 30, 1949)*—Continued

State	Number of projects	Size of community					
		Under 2,500	2,500 to 4,999	5,000 to 9,999	10,000 to 24,999	25,000 to 49,999	50,000 and over
Tennessee	14	2	4	4	3	1	--------
Texas	47	22	3	9	5	2	6
Utah	5	2	1	--------	1	--------	1
Vermont	4	1	--------	2	1	--------	--------
Virginia	11	3	2	1	4	--------	1
Washington	9	5	3	--------	--------	1	--------
West Virginia	3	--------	--------	1	1	--------	1
Wisconsin	8	2	4	1	--------	--------	1
Wyoming	2	2	--------	--------	--------	--------	--------
Alaska	1	1	--------	--------	--------	--------	--------
Puerto Rico	3	--------	--------	--------	--------	--------	3

[1] Includes applications for replacements, additions, and alterations as well as for new general hospital projects.

TABLE V.—*Distribution of new general hospitals by size of community (as of Apr. 30, 1949)*

State	Number of projects	Size of community					
		Under 2,500	2,500 to 4,999	5,000 to 9,999	10,000 to 24,999	25,000 to 49,999	50,000 and over
Total	360	154	93	62	33	4	14
Alabama	13	4	3	--------	--------	1	5
Arizona	1	--------	--------	1	--------	--------	--------
Arkansas	11	--------	7	4	--------	--------	--------
California	20	12	5	2	1	--------	--------
Colorado	6	2	3	1	--------	--------	--------
Florida	9	1	4	--------	2	1	1
Georgia	12	5	1	3	1	--------	2
Idaho	5	2	2	1	--------	--------	--------
Illinois	9	--------	4	3	2	--------	--------
Indiana	12	4	4	4	--------	--------	--------
Iowa	11	3	7	1	--------	--------	--------
Kansas	11	6	2	2	1	--------	--------
Kentucky	11	8	1	1	1	--------	--------
Louisiana	6	1	3	--------	1	1	--------
Maryland	1	1	--------	--------	--------	--------	--------
Massachusetts	2	--------	--------	--------	2	--------	--------
Michigan	5	--------	1	3	--------	--------	1
Minnesota	10	7	2	1	--------	--------	--------
Mississippi	32	19	7	1	5	--------	--------
Missouri	5	--------	2	2	--------	--------	1
Montana	6	4	2	--------	--------	--------	--------
Nebraska	14	9	4	--------	1	--------	--------
New Jersey	1	1	--------	--------	--------	--------	--------
New Mexico	6	2	1	2	1	--------	--------
New York	8	2	3	2	1	--------	--------
North Carolina	21	10	7	2	2	--------	--------
North Dakota	2	2	--------	--------	--------	--------	--------
Ohio	13	--------	3	6	4	--------	--------
Oklahoma	16	6	5	3	1	--------	1
Oregon	2	1	1	--------	--------	--------	--------
Pennsylvania	4	1	--------	2	1	--------	--------
Rhode Island	1	--------	--------	--------	--------	1	
South Carolina	6	3	1	2	--------	--------	--------
South Dakota	7	7	--------	--------	--------	--------	--------
Tennessee	8	1	3	3	1	--------	--------
Texas	33	20	2	7	3	--------	1
Utah	2	1	--------	--------	--------	--------	1
Vermont	1	--------	--------	1	--------	--------	--------
Virginia	4	2	--------	--------	2	--------	--------
Washington	4	3	1	--------	--------	--------	--------
West Virginia	3	1	--------	1	--------	--------	1
Wisconsin	4	1	2	1	--------	--------	--------
Wyoming	1	1	--------	--------	--------	--------	--------
Alaska	1	1	--------	--------	--------	--------	--------

TABLE VI.—*Distribution of new general hospitals in each State by size of hospital (as of Apr. 30, 1949)*

State	Number of projects	Size of hospital					
		Under 25 beds	25 to 49 beds	50 to 74 beds	75 to 99 beds	100 and over beds	Unknown [1]
Totals	360	80	133	74	13	48	12
Alabama	13	2	4	1	1	4	1
Arizona	1	--------	1	--------	--------	--------	--------
Arkansas	11	--------	8	2	1	--------	--------
California	20	4	9	3	--------	2	2
Colorado	6	2	3	1	--------	--------	--------
Florida	9	--------	4	3	--------	2	--------
Georgia	12	1	5	1	--------	4	1
Idaho	5	--------	4	--------	1	--------	--------
Illinois	9	--------	--------	6	--------	3	--------
Indiana	12	2	4	4	2	--------	--------
Iowa	11	3	6	2	--------	--------	--------
Kansas	11	6	4	1	--------	--------	--------
Kentucky	11	4	5	1	--------	1	--------
Louisiana	6	--------	1	3	--------	1	1
Maryland	1	--------	1	--------	--------	--------	--------
Massachusetts	2	--------	1	--------	--------	--------	1
Michigan	5	--------	2	--------	--------	3	--------
Minnesota	10	3	5	2	--------	--------	--------
Mississippi	32	3	15	7	1	5	1
Missouri	5	--------	--------	4	--------	1	--------
Montana	6	4	2	--------	--------	--------	--------
Nebraska	14	9	3	--------	1	--------	1
New Jersey	1	--------	1	--------	--------	--------	--------
New Mexico	6	1	3	--------	2	--------	--------
New York	8	--------	2	4	--------	2	--------
North Carolina	21	6	3	3	--------	9	--------
North Dakota	2	--------	2	--------	--------	--------	--------
Ohio	13	1	3	7	1	1	--------
Oklahoma	16	5	5	2	--------	1	3
Oregon	2	1	1	--------	--------	--------	--------
Pennsylvania	4	1	--------	2	--------	1	--------
Rhode Island	1	--------	--------	--------	1	--------	--------
South Carolina	6	--------	2	4	--------	--------	--------
South Dakota	7	3	4	--------	--------	--------	--------
Tennessee	8	--------	3	4	--------	1	--------
Texas	33	17	9	3	2	2	--------
Utah	2	--------	1	1	--------	--------	--------
Vermont	1	--------	--------	1	--------	--------	--------
Virginia	4	--------	2	--------	--------	2	--------
Washington	4	2	1	--------	--------	--------	1
West Virginia	3	--------	--------	--------	--------	3	--------
Wisconsin	4	--------	2	2	--------	--------	--------
Wyoming	1	--------	1	--------	--------	--------	--------
Alaska	1	--------	1	--------	--------	--------	--------

[1] Includes new projects for which funds for equipment only are provided; the number of beds in these facilities is not reported.

Mr. PRIEST. Dr. Dearing, on behalf of the committee, in the first place, I want to express our appreciation for the manner in which you have presented your statement and the large number of very helpful exhibits that you have included in the appendixes of your statement. I think the information contained in these, when we have time to digest it, is about all we are looking for and perhaps will answer any questions that the committee might have in mind, and we do appreciate that.

I have one or two questions. I gathered from your testimony that on the retroactive features, you had no serious objection to the retroactive provision as of January 1, 1949, but that you seriously object to making it retroactive to August 13, 1946; is that generally correct?

Dr. DEARING. Well, Mr. Chairman, it is generally correct, although going back to January 1, 1949, also seems unnecessary. The one justification that we can see for the retroactive provision is when a bill is pending that some might hold off until they got their larger share, and a retroactive provision should go back far enough only to protect against that. Any retroactivity which is introduced, which goes further than that, would be drawing off money which we feel was intended and should be used for new projects rather than to fatten up some that are already committed. This is an assisting and a stimulating program, with the final and the main responsibility still with the States and the communities.

Mr. PRIEST. Now, Doctor, most all of the bills, including the titles in the omnibus bill, and H. R. 2176, and many of the others, include, as I understand it, about five principal proposals. First, of course, is to extend the duration period.

Dr. DEARING. Yes, sir.

Mr. PRIEST. Of the program. Do you favor that provision, provided it is in proper language?

Dr. DEARING. Very strongly.

Mr. PRIEST. The extension of the duration of the program.

Dr. DEARING. Yes, sir.

Mr. PRIEST. Most of the bills, I think, call for a doubling of the Federal allotment to the States from $75,000,000 a year to $150,000,000.

Dr. DEARING. Yes, sir.

Mr. PRIEST. And that also meets with the approval of the agency and the Public Health Service?

Dr. DEARING. That is so, because the present limitation will meet only about 10 percent of the need as demonstrated by the careful State surveys and the doubling of the allotment will enable us to take a larger bite out of the problem.

Mr. PRIEST. Did I understand from your statement—I could check back, but you can give me the figures—as I understand that present estimates indicate that there is a shortage of something like 890,000 hospital beds; close to 1,000,000?

Dr. DEARING. Yes, sir. We really have just about half of what we need. There are now 880,000 acceptable, and 897,000 additional beds are needed.

Mr. PRIEST. Now, Doctor, you covered in somewhat of a general way in your statement, the question of the increase in the Federal share and percentage which sometimes gets confused with our Federal allotments and Federal share. Will you amplify just a little more in detail what you think about the proposals for increasing the Federal share?

Dr. DEARING. Well, Mr. Chairman, to review, the current bill does provide for varied allotments to the States, so that the poorer States can have allotted to them a larger proportion of the $75,000,000 a year; but the Federal share is fixed at a flat one-third, under the current bill. So that, although Mississippi gets a large allotment in relation to her population from the Federal grant, she still has to find $2 for every Federal dollar that is put in and that limitation, for a State as a whole, or particularly for the poorest communities in the State, means that some of them just cannot build hospitals and we find that many of the high-priority areas, the poorer areas, are not able to come in at all because of that requirement to dig up the $2 for every Federal dollar that goes into the project.

Mr. PRIEST. All those States that have in those areas, as you say, have the highest percentage of allotments?

Dr. DEARING. Their share of whatever is built is exactly the same.

Mr. PRIEST. That is right.

Dr. DEARING. And there are these various proposals for increasing the Federal share. Some would be at the discretion of the State and some of the bills, as I understand them, would fix in the congressional act the Federal share, making it the State's allotment percentage, and that is a little less flexible than we think would be desirable.

Mr. PRIEST. Well, that was my next question. Of the proposals suggested, which do you prefer? That is, the discretion within the State agency or spelling it out in legislation, making it statutory?

Dr. DEARING. We prefer the discretion by the State agency with the Congress setting the limits, as would be provided in the omnibus bill. The Federal share cannot fall below the one-third and the State might not set a Federal share above 66⅔ or the allotment percentage, whichever is the lower.

Mr. PRIEST. I may have some other questions later, but I do not want to take all of the time.

Mr. Bennett, perhaps you have some questions.

Mr. BENNETT. Yes, Mr. Chairman.

Continuing along that line, let us take the State of Mississippi, for example. Suppose under the State-allotment system they would be entitled to, say, $5,000,000. How would it then be determined what amount the State would add to that $5,000,000 as its share?

Dr. DEARING. Well, sir, the State would determine it. It would not necessarily require that the State per se add anything. They may or may not. The only requirement is that the money comes from elsewhere than the Federal funds. Some States put in part of the costs and others have done nothing, and let the communities, by tax funds or by private subscriptions or whatever, raise the extra funds; but the provisions which we favor would allow the State of Mississippi to determine the Federal share of the project. They would determine it under their State plan, as I understand it. They would determine the State share of the project and vary that share of the project depending upon the wealth and the ability of the given community to raise the funds.

Mr. BENNETT. Would the $5,000,000 which I assume might go to Mississippi actually build $15,000,000 worth of hospitals?

Dr. DEARING. No, sir; it would not.

Mr. BENNETT. How much would it build?

Dr. DEARING. Well, if the State determined that the Federal share would be the maximum allowable, which would be 66⅔, would it not?

Dr. HOGE. Yes.

Dr. DEARING. Then it would build only one-half of that, which would be $7,500,000, I think, worth of construction. That would be allowing the maximum Federal share which would presumably be justifiable only in the poorer areas.

Mr. BENNETT. Then, as I understand it, under the program that you have in mind, any State could limit the amount that it would contribute to the program to 33⅓ percent and use 66⅔ percent Federal funds?

Dr. DEARING. No, sir; only if the allotment percentage were that high, and if you will turn to tab A here, in the last column, you can see that the great majority of the allotment percentages are below this two-thirds. For your own State, for example, it is 43 percent, and that would be the maximum that the Michigan State plan could allow as the Federal share in any project and the flexibility which we advocate would allow the States desiring to spread the money further, to do so in order to help as many projects as possible. They would allow this maximum Federal share only for the poorest projects, the communities which were having the greatest trouble raising money, and would be able to hold the Federal share down to one-third, at the State's discretion, in other communities which should put up more.

Mr. BENNETT. I see. Well, then, it is up to the State to determine within this limitation how much each community shall be required to put up.

Dr. DEARING. How much the State puts in, if the State is putting in money.

As I said, 10 States have quite a substantial program of State aid and are systematically putting some support into each community project.

Mr. BENNETT. So a State would have the right to say, if $10,000,000 is to be spent on a project, it would have the right to say to the sponsor, you put up $3,333,333 of your own, or the State could say to the community under the same circumstances, you put up $6,666,666, and we will give you $3,333,000, but $3,333,000 would come from the Federal Government.

Dr. DEARING. That is the way it would work out with any State whose allotment percentage was 66⅔ percent. Some of them run up to 75 percent. But, if the allotment percentage is only 50 percent——

Mr. BENNETT (interposing). Then, how do you determine the allotment percentage? That is an interesting question.

Dr. DEARING. Well, that allotment percentage——

Mr. BENNETT. Is a litle bit complicated, is it not?

Dr. DEARING. It is a mathematical index which was worked out after trying several different ways of doing this thing, which was laid before the committee at the time that the original national act was passed. Several ways of trying to weight income and population and need for determining the allotments were considered.

Mr. BENNETT. Well, let me put it this way. Suppose the allotment, the total Federal appropriation, for the next fiscal year were $150,000,000. Under the formula set up in H. R. 4312, could you determine in advance under that formula what Mississippi would get; what Michigan would get; or what California would get?

Dr. DEARING. Yes, sir.

Mr. BENNETT. All right; let us take an example and see how it would work out.

Dr. DEARING. These percentages that are given in the last column here in appendix A, are worked out in accordance with the formula which is set forth in the law and they would not change, whether the total appropriation was $75,000,000 or $150,000,000. I can refer, if you wish, to the method of working out the formula which is in the Public Health Service Act, section 631. It reads:

> SEC. 631. For the purposes of this title—
>
> (a) the allotment percentage for any State shall be 100 per centum less that percentage which bears the same ratio to 50 per centum as the per capita income of such State bears to the per capita income of the continental

> United States (excluding Alaska), except that (1) the allotment percentage shall in no case be more than 75 per centum or less than 33⅓ per centum and (2) the allotment percentage for Alaska and Hawaii shall be 50 per centum each, and the allotment percentage for Puerto Rico shall be 75 per centum;

But it is a weighted process which the mathematicians developed when the act was first under consideration, and was determined to be a satisfactory formula and is the one which is still being used.

Mr. Priest. Will the gentleman yield?

Mr. Bennett. Yes.

Mr. Priest. During the years before the gentleman from Michigan [Mr. Bennett] was a member of the subcommittee and at a time when the chairman was a member, may I say, that we worked on that formula with mathematicians and others for about 3 weeks and at the end of the 3 weeks, a glimmer of understanding came into my consciousness at that time; but enough to convince me that it was a very sound formula. I think I know about as much about the mathematics of the formula as I do about nuclear physics, but I do know enough to believe that it is probably the best formula that could be worked out on the allotments.

Mr. Bennett. It seems to me, Mr. Chairman, some kind of a formula could be worked out that an ordinary Member of Congress could understand. Maybe that is not possible.

Mr. Priest. Well, this formula, may I say, sounds more complicated than it really is. When you take it and reduce it to figures, it is not nearly as complicated as it sounds in the act.

Dr. Dearing. It is much easier to understand in figures, I think, than it is in the words in the act.

Mr. Priest. Much easier.

Mr. Bennett. Let me ask this. On appendix A, for example, you have a column stating an allotment of 70.22. Well, 70.22 of what?

Dr. Dearing. Nothing. It is really an index. The percentage—I have always felt that the term or the column under "Allotment Percentages" is really misleading. It is an index figure which is, I believe, squared and then applied against the population of the State and from there you get a true percentage which gives the proportion of $75,000,000 that each State gets.

Mr. Bennett. Can you translate the 70.22 percentage into dollars?

Dr. Dearing. It is translated into dollars here, at the top of the next column to the left, to mean $2,690,543.

Mr. Bennett. Now, if you had $150,000,000 it would be double that figure?

Dr. Dearing. Yes, sir.

Mr. Bennett. So that if the appropriation were $150,000,000 you could take appendix A of your report and double each of the figures for the 48 States and have the amount each State would get?

Dr. Dearing. For fiscal 1950; yes, sir.

Mr. Bennett. For fiscal 1950.

Dr. Dearing. Yes, sir.

Mr. Bennett. Would that work out the same under this omnibus bill?

Dr. Dearing. Yes, sir; the bill would not change the formula.

Mr. Bennett. H. R. 4312 does not change the formula that is in the act now?

Dr. DEARING. That is correct. I would point out, though, as I say, this allotment percentage may be a misnomer in that it is not a percent of anything. At the same time, it would assume the nature of a ceiling on the Federal share if the provisions of the omnibus bill were enacted. So that would give new significance to this so-called allotment percentage in that it would at least then be a ceiling on the Federal share.

Mr. BENNETT. And what about the two-thirds and one-third arrangement?

Dr. DEARING. Those would be maximum and minimum limits in any case.

Mr. BENNETT. And that is, Is that the way the Hill-Burton Act is working out now?

Dr. DEARING. Yes, sir. Well, there is no variable Federal share in the present Hill-Burton Act.

Mr. BENNETT. When we talk about variable Federal shares in connection with the States, that is something new?

Dr. DEARING. That is correct. The present Federal share is fixed at one-third.

Mr. BENNETT. I see. I just have two or three more questions.

Mr. PRIEST. All right.

Mr. BENNETT. Is there any limit on the amount that any State can expend on any one hospital?

Dr. DEARING. Not in the Federal statute, sir; not on the cost of a hospital. The needs of any particular area for a hospital are set forth in the State plan which must be approved by the Surgeon General before it becomes operative. The general requirements for a State plan, what priority shall be observed and the principles under which the State plan shall be drawn, with attention to rural areas and shortage areas, are set forth in the statute, but the State then sets up its plan on the basis of its own survey, and submits that to the Surgeon General for approval. Other than this there is no Federal statutory limit on the size of any particular project.

Mr. BENNETT. Under this bill, the Surgeon General has the final veto on any project whatsoever in the program, does he not?

Dr. DEARING. He has the responsibility to approve the plan and then he has the responsibility to approve the individual project as submitted under the plan for conformity with the plan and for conformity to standards set under the regulations which have to be approved by the Federal Hospital Council; and then any applicant has the statutory right of an appeal.

Mr. BENNETT. To whom?

Dr. DEARING. To the Council, to the Federal Hospital Council. The applicant has the right to appeal to the Federal Hospital Council over the head of the Surgeon General, if he is dissatisfied with the disapproval of the project.

Mr. BENNETT. Who is on that Council?

Dr. DEARING. There are eight members; four public and four hospital and medical authorities.

Mr. WILSON. Will the gentleman yield?

Mr. BENNETT. Yes.

Mr. WILSON. Would it be possible to name those on that Council?

Dr. DEARING. Yes, sir. Can you name them, Dr. Reed?

Dr. Reed is head of the research staff, Hospital Facilities Division.

Dr. REED. Dr. Buerki of the University of Pennsylvania.

Dr. DEARING. He is vice president.

Dr. REED. Dr. Paulin of Emory University Medical School in Atlanta.

Dr. DEARING. A past president of the American Medical Association.

Dr. REED. Mr. Graham Davis of the Kellogg Foundation.

Dr. DEARING. Past president of the American Hospital Association.

Dr. REED. Reverend Curry of the division of health and hospitals of the Catholic Charities Association.

Dr. A. W. Dent.

Dr. DEARING. Of the Dillard University.

Dr. REED. Mr. Cruikshank of the American Federation of Labor.

Dr. DEARING. Mr. Fichter of the Grange.

Dr. REED. And then there is a vacancy created by Dr. Frank Graham, who was on the Council and he resigned when he became a Senator.

Dr. DEARING. There are seven members now.

Mr. WILSON. You will remember, Mr. Chairman, that Mr. Cruikshank was one of the witnesses before us some weeks ago when we were talking about the same subject, on behalf of the labor organizations.

May I ask further, if the gentleman will yield?

Mr. BENNETT. Yes.

Mr. WILSON. Who was the Kellogg you spoke of?

Dr. DEARING. This is Mr. Davis of the Kellogg Foundation.

Mr. WILSON. Is that the W. S. Kellogg Foundation?

Dr. DEARING. Battle Creek; I am not sure.

Mr. WILSON. I noted with great pleasure the day before yesterday they made a grant of $130,000 to the medical school, University of Oklahoma, for the increasing of the staff by several members of the medical school. It is one of four universities to be fortunate enough to receive such a grant at this time.

Dr. DEARING. W. K., we think, are the initials. May I correct myself. The applicant does not have the right of appeal to the Federal Hospital Council, but the State, on behalf of the applicant, may appeal to the United States circuit court of appeals.

Mr. PRIEST. Mr. Bennett, do you have an further questions?

Mr. BENNETT. Yes; I have two or three other questions.

I note, Doctor, that you are opposed to any of the funds provided here being used retroactively back of January 1 of this year.

Dr. DEARING. Yes, sir.

Mr. BENNETT. My attention has been called to a situation in my own State of Michigan—not in my district—but in Marlette, Mich., where authority to build a hospital was obtained in June last year; June 1948. Local funds were raised to the extent of $100,000. The hospital is to cost $160,000. Well, these people have reached the limit to what they can do locally, and the project, as I understand it, has been discontinued or work has been discontinued on it and it is standing there in any incompleted state.

Now, what are we going to do with projects like that?

Mr. DEARING. Well, I suppose any cut-off date means something, if somebody is cut off. There is no question about that. And I suspect there are others where rising costs have just priced a few of them out of the market.

Mr. **Bennett.** Would you not agree that where a community has gone out and taken every last dollar they could get from the people locally to build a hospital, that there could not be any question but what there must be a necessity for it?

Dr. **Dearing.** That is right, I think.

Mr. **Bennett.** Would not that kind of a case where they have contributed to the maximum of their ability and have this incompleted hospital, seem to be one where the Federal Government ought to go in and finish that before it starts something somewhere else?

Dr. **Dearing.** Some method ought to be found for finishing it. We think the States have some responsibility in this, too, although not all of them have picked it up. That is another possible source of funds.

Mr. **Bennett.** The State really, in this case, has put in two-thirds of the money; that is, the people of the community, the local community have made their contributions.

Dr. **Dearing.** That is very true.

Mr. **Bennett.** If we cut that date off as of January 1, 1949, you are going to leave probably a number of projects around the country that are worth while, leave them right out on the end of a limb and start in with something else that may not be any more necessary at all than the ones we are talking about.

I am wondering if you fix an arbitrary date what is going to happen to these kind of cases.

Dr. **Dearing.** Well, there is no answer, as I see it, to the cases of that sort, if you have an arbitrary date. Of course, I would suggest that the August 13, 1946 date is arbitrary. That happens to be when the President signed the bill. We have had a great many projects which were started before that time which were badly needed, and again they were priced out of the market, and they have said, "Is there not some way that we can get some help to complete our projects?" And, the answer is the same right there as it would be as of January 1, 1949, or any other date which would exclude a project, if that were enacted.

Mr. **Bennett.** Well, would you object to an amendment that would give, say, the State hospital authorities in Michigan or any State, acting with the Surgeon General, the right to review these kind of projects, and if they found to be worth while, and necessary, that then funds could be provided under the bill?

Dr. **Dearing.** Well, sir, I do not think we would object to such an amendment if the Congress thought that feasible. We are simply pointing out, one, that it is a new principle in Federal grants to put a retroactive clause in, and second, that some of the funds would go for old projects instead of new ones, and really the final decision is up to the committee and the Congress.

Mr. **Priest.** I think we all recognize that the question of retroactivity is a rather difficult one. Since Mr. Bennett has suggested this particular project, and in line with what you have had to say, Doctor, about the necessity of having some cut off date, I recall an instance of a hospital that was started, they built the basement and one or two floors of the building 10 years ago, and local funds and State funds and municipal funds, were exhausted. They conducted a public subscription campaign without success, for that construction. I have had the same question raised in connection with that project, asking if we could not make it retroactive to include that project, started 10 years before the act. This presents another phase of this question of retroactivity and the difficulty in reaching a decision on it.

Mr. Sadowski, do you have a question?

Mr. SADOWSKI. Yes. How many of those types of hospitals have we that are not complted and do not come in under the present act?

Dr. DEARING. Do you have any idea, Dr. Hoge?

Dr. HOGE. There should not be very many hospitals started that could not be completed, because under the procedures, the money has to be in sight before starting construction.

Mr. PRIEST. Will the gentleman yield?

Mr. SADOWSKI. Yes, sir. What I mean to say is: How many projects have you like the Mardette project, for instance, which are not included in the present act?

Dr. DEARING. Of the type that the chairman was speaking about which were started 10 years ago and which they have not been able to complete?

Mr. SADOWSKI. That is right. I will include that. How many of those projects have we?

Dr. HOGE. You mean projects of that type?

Mr. SADOWSKI. That is right, which need aid and assistance to help them along toward completion.

Dr. HOGE. We have no data on that. I do not think we have many.

Mr. SADOWSKI. Then, if there are not very many, is it not logical to say that we ought to help those projects out? Certainly we do not want to let that money go to waste.

Dr. HOGE. Such a project would be eligible under the present act, Mr. Chairman. If a hospital had been started back before this program went into effect—and there were some at that time that were standing half completed—then the completion of that hospital is an eligible project under the present program.

Mr. PRIEST. Provided it is included in the State plan.

Dr. DEARING. If the State survey shows that it is where a hospital ought to be, and of that size, and so on, the State can put it in its plan.

Mr. BENNETT. Will the gentleman yield?

Mr. SADOWSKI. Can the State put it in its plan now, or is the State barred from putting it in its plan?

Dr. HOGE. No, the State can change its plan any time; can add any new projects it sees fit.

Dr. DEARING. And is required to revise its plan once a year, and bring it up to date.

Mr. BENNETT. Will the gentleman yield?

Mr. SADOWSKI. Yes, I will yield.

Mr. BENNETT. This project at Marlette was started, as I understand, June 1, 1948.

Dr. HOGE. That came under the program, then, and if I understood you, Mr. Bennett, they did not have money, enough money, to finish the project.

Mr. BENNETT. They raised $100,000 and the project is to cost $160,000, approximately.

Dr. HOGE. Well, it sometimes happens that the total cost is underestimated, in which case the application can be amended and an increased amount of Federal money put into it to finish it up.

Mr. PRIEST. Will the gentleman yield?

Mr. BENNETT. Yes.

Mr. PRIEST. I think, however, that there still may be a misunderstanding. Is the hospital at Marlette included in the Michigan State plan?

Mr. BENNETT. I cannot answer that.

Mr. SADOWSKI. Is there a representative here from Marlette?

Mr. BENNETT. Yes, there is a representative here. Mr. Robinson is here.

STATEMENT OF BERT ROBINSON, CHAIRMAN, MARLETTE HOSPITAL BOARD, AND PRESIDENT, STATE PHARMACEUTICAL ASSOCIATION, MARLETTE, MICH.

Mr. ROBINSON. No, it is not included, because their application was not accepted, due to the fact that they had some plan whereby they had districts set up in Michigan. I do not know who devised the plan. I think it was somebody outside of your department. They were using this plan. We applied but could not get money for the purpose of building this hospital because it was not in proper relation to the plan. They had approved a location 20 miles—in fact, 19 miles from us, and since that time this community has not been able to raise the money. They cannot come under the act. And there has been a relocation, proposed location of hospitals, and now we do come under the act and our hospital has been built according to the specifications of your department, and a good architect was engaged.

Mr. BENNETT. The State agency approved your hospital?

Mr. ROBINSON. The State agency has approved it now, but that does not do us any good, because this is not retroactive. In other words, law 725 says that it must have been approved by the attorney general and your department before they will accept any project.

So we do not get approval, due to no fault of our own, and now we cannot participate in the plan because it was not approved before. That is our local condition. However, the State has approved it now.

Mr. SADOWSKI. Would we have to have an amendment to this bill in order to include your project?

Mr. ROBINSON. Yes, sir. There is one bill—I believe it is embraced in 1721, which has been offered here—that would take care of that situation. And I understand that is not an isolated condition. This is just another example of the thing we are talking about. There are a number of those.

Mr. Hugh J. McGoldrick, director of Office of Hospital Survey and Construction, State of Michigan, State Capitol, Lansing, Mich., has furnished a list of those. There are 55 such pick-up projects. They are probably not all exactly the same, but they are similar.

Mr. SADOWSKI. Fifty-five such projects where?

Mr. ROBINSON. In 37 different States.

Mr. PRIEST. Will the gentleman yield for one question of Dr. Dearing?

Mr. SADOWSKI. Yes.

Mr. PRIEST. Let me ask you this question. The State agencies are required annually to revise their programs and plans?

Dr. DEARING. Yes, sir; and may do so at any time they desire, in addition to the requirement.

Mr. Priest. Let me further ask this question as a follow-up to that. Assuming that the State agency in the State of Michigan revised their plan next year and, after considering all elements, the State agency decided that it was advisable and in the public interest to include this Marlette project in the State plan. If that plan then were approved by the Surgeon General or the Hospital Council in the revised State plan, then no legislation would be necessary in order for this hospital to receive some assistance?

Dr. Dearing. That is my understanding, sir; I would assume that, if it were a hospital which were started outside of the State plan and then was later, by revision of the plan, included, it would then become eligible to apply under present law for a grant to complete construction.

Mr. Bennett. Would it be correct to say this, if a revised plan on this Marlette hospital were filed and approved by the State agency and sent here, would they be in a category of a new current project rather than a retroactive project?

Dr. Dearing. That is correct. They could come in as a new project for completion because, as Dr. Hoge says, there is authority to make grants for completion of hospitals already started before the act, under the plan. We could not pick up, I believe, could not go back and put in a portion of what had already been expended, but we could put in a share of what it would take to complete it.

Mr. Bennett. You could do that on the basis of it being a current, new project and not a retroactive project.

Dr. Dearing. Yes, sir.

Mr. Robinson. Mr. Chairman, I would like to point out that that would not take care of our situation, because we have exhausted all of our resources for raising money and that would only take the plan from here on in after we have already spent a hundred thousand dollars, and then all that we could participate in would be one-third of the cost of finishing the project, which would not amount to a sufficient sum.

Dr. Dearing. Yes.

Mr. Bennett. Is that all you could do under the current provisions?

Mr. Priest. That is true under the law.

Mr. Bennett. So, if they needed $60,000, that still would not be sufficient, because all you could get under the new arrangement, I take it, would be $20,000.

Dr. Dearing. That is correct, unless under the revision, under these amendments, if it were permitted to go up to the allotment percentage of Michigan, which would be 43 percent, instead of one-third. That would be the maximum if it were treated as a new project in this way.

Mr. Sadowski. When did you make your application?

Mr. Robinson. Sometime—I cannot give you the exact date. It was before June 1, 1948. At that time we had a different director of the office in Lansing.

Another thing that I would like to point out, while this retroactive clause such as is contained in 1721 would take care of some, it would not produce probably the desired results, because some of that money could be used, as the doctor says, for building new hospitals. Yet this would furnish new beds, furnish more beds, which I believe, in turn, was intended in the act in the first place—furnish more hospital facilities.

Mr. SADOWSKI. Now, you say that we have a new director of hospitals in Michigan.

Mr. ROBINSON. Yes, sir.

Mr. SADOWSKI. The new director is favorable toward your project being included?

Mr. ROBINSON. That is correct.

Mr. SADOWSKI. Under the law as written, it cannot be done even though he wants to do it?

Mr. ROBINSON. They want it but cannot do it. In fact, the Governor of Michigan has taken the liberty of writing, I believe, several Congressmen, asking them to do something for that particular project up there, but I do not believe that this should be considered as an isolated situation, due to the fact that you have similar projects to the number of 55 in 37 States. In fact, with the permission of the chairman, I would like to read Mr. McGoldrick's statement.

Mr. PRIEST. The gentleman is scheduled as a witness later. I was wondering if we might not perhaps proceed with questions to Dr. Dearing and then get your complete statement on the subject a little later on.

Mr. BENNETT. Unless he has finished his statement.

Have you said all you want to say? If you have not, then you had better wait.

Mr. ROBINSON. Other than reading this. Mr. McGoldrick could not be here today, so I have a statement from Mr. McGoldrick regarding the situation there.

Mr. SADOWSKI. That statement would be important to me, and I would like to hear that statement, and I would like to have the Assistant Surgeon General present so that we may be able to ask him further questions regarding that statement.

Mr. PRIEST. May the chairman inquire, how long is that statement which you have?

Mr. ROBINSON. It is a two-page statement.

Mr. PRIEST. This is a little irregular from the procedure standpoint but, without objection, I think you may proceed with that statement while Dr. Dearing is here and, if there are any questions, we can ask them at the time.

Mr. SADOWSKI. I would like to hear the statement read.

Mr. ROBINSON. It is addressed to Mr. Crosser and reads as follows:

> As director of the hospital survey and construction program for the State of Michigan, I feel it is my duty to bring to the attention of the members of your committee the following pertinent facts relative to consideration of H. R. 1721.
>
> Retroactive payments are absolutely necessary to complete some projects now lying idle because of insufficient funds. This fact remains true even though under the existing law we are allowed to give one-third of the costs necessary to complete construction. This can be proved by a specific case in the State of Michigan and which I believe also exists in other States.
>
> In Marlette, Mich., a 22-bed nonprofit community general hospital now lies only 62 percent completed because funds for completion are not available. I do believe, however, that passage of H. R. 1721 would give the community one-third of the cost of that portion completed as well as one-third of costs necessary to complete construction and equip the hospital.
>
> Figures obtained from the Federal Security Agency show other States have the same problem.
>
> For you consideration I list the other States which have picked up projects and the amount of Federal participation involved.

State	Number of pick-ups	Total cost	Federal share	State	Number of pick-ups	Total cost	Federal share
Total	55	25, 525, 989	7, 055, 598	Michigan	1	319, 313	92, 439
				Minnesota	1	223, 607	73, 554
Alabama	1	996, 470	332, 156	Montana	1	297, 692	98, 244
Arkansas	1	221, 295	73, 765	Nevada	1	230, 252	6, 885
California	1	229, 179	73, 983	New Jersey	3	2, 884, 613	907, 749
Colorado	2	3, 130, 286	609, 892	New Mexico	1	50, 954	15, 650
Connecticut	1	103, 680	34, 560	New York	1	390, 336	130, 112
Florida	3	1, 370, 736	419, 381	North Carolina	2	246, 197	82, 065
Georgia	1	15, 525	5, 175	North Dakota	1	287, 730	95, 910
Illinois	1	1, 088, 762	236, 050	Ohio	2	1, 392, 913	195, 830
Indiana	1	55, 387	9, 681	Oklahoma	5	412, 858	136, 166
Iowa	1	659, 874	195, 324	Oregon	1	45, 000	15, 000
Kansas	2	720, 740	236, 580	Pennsylvania	2	2, 203, 577	610, 783
Kentucky	1	884, 566	294, 855	South Carolina	2	729, 073	243, 024
Louisiana	5	3, 949, 450	1, 130, 087	Tennessee	1	300, 000	100, 000
Maine	1	187, 569	47, 991	Texas	5	1, 101, 033	286, 933
Maryland	1	100, 440	33, 480	Washington	1	35, 698	11, 899
Massachusetts	1	661, 184	220, 394				

Abuses of the original intent of Public Law 725 are protected by the necessity of approval of retroactive payments at both the State and Federal level.

In view of the amount of good that can be obtained, I urge your immediate recommendation of passage.

Many thanks to you and the members of your committee.

Sincerely yours,

HUGH J. McGOLDRICK,
Director, Office of Hospital Survey and Construction, Lansing.

Mr. SADOWSKI. Doctor, do you agree with that statement?

Dr. DEARING. Assuming that the information on the list of projects is accurate, I would think it to be in essence correct; that as regards the bill under consideration, what it would do, and with regard to the safeguards, yes.

Mr. SADOWSKI. He states here that the uses of the original intent of Public Law 725 are protected by the necessity of approval of retroactive payments at both the State and Federal levels?

Dr. DEARING. Yes, sir.

Mr. SADOWSKI. That seems like a sound statement.

Dr. DEARING. I would think so.

Mr. SADOWSKI. And it should be possible to work something out in a situation of this kind.

Dr. DEARING. Well, sir, as I indicated, I mean simply to call attention to the problems involved and realize that it is the responsibility and the final decision of Congress as to what to do about this really tough problem.

Mr. SADOWSKI. It would mean new legislation, would it not?

Dr. DEARING. It would mean, sir, that some new authority—there is absolutely no authority in the present law as we interpret it.

Mr. BENNETT. Will the gentleman yield?

Mr. SADOWSKI. Yes.

Dr. DEARING. It would mean the type of amendments which have been suggested.

Mr. BENNETT. The difficulty, as I see it, is that as the record stands now the Federal Security Agency and the Surgeon General are on record as opposed to any retroactive feature in this bill back of January 1 of this year.

Now, what I would like to see, if we could reach that point, is some suggestion from the Surgeon General, who has undoubtedly given this matter much more thought and study than we have, as to how an amendment could be written here to take care of what I would say are hardship cases without putting a dead line, as you suggested.

Dr. Dearing. Yes. Well, sir, may I request permission to take this under further advisement on the instruction of the committee?

Mr. Priest. Very well.

Dr. Dearing. Several of the bills cover this problem and they differ somewhat. If we have your permission to study it a little further and to submit to the committee our best judgment on the matter, perhaps that will take care of it.

Mr. Bennett. Yes.

Mr. Priest. I think that might be helpful.

I repeat again that all of us are aware that when you start a retroactive clause in a bill, there is hardly any end to it. You continually get pressures dating on back.

As I see it, it is a rather dangerous precedent in Federal aid and yet we face practical situations, 55 the gentleman has listed, and it might be possible that something might be worked out to render that assistance without departing on a new policy in Federal aid of a retroactive feature that I can see is very, very dangerous because it is so difficult to say when it shall stop. If we put it back to August 1956, immediately we will have 10 other projects that were started in June of 1946. They feel that they are just as worthy and perhaps they are and just as needy. It is an extremely difficult situation but if you will help us, maybe we can try.

Dr. Dearing. Yes, sir. One of the saddest features is that the community which did come forward and was progressive enough to take the move is in a way penalized.

Mr. Priest. That is right.

Dr. Dearing. Where there was not anybody to come along and help him out.

Mr. Bennett. Mr. Chairman, do you not believe that it would be better in considering the matter to leave out the retractive dates and simply try to work out some arrangement where you could leave the matter to the discretion of the State, working with the Surgeon General's office and so on?

Mr. Priest. That would be safer insofar as setting a precedent, as I see it, of retroactive aid. I would very must want to be absent from any committee attempting to decide on the merits of projects.

I think it would present a rather great difficulty to any group making the decisions and yet the setting of the date certainly is a precedent we should steer away from if possible.

Mr. Wilson, do you have any questions?

Mr. Wilson. Not at the moment.

Mr. Priest. Did you have any questions, Mr. Sadowski?

Mr. Sadowski. While I am thinking about this problem in Michigan, if we have two hospitals in our State that the present director feels should be completed and should come in under this program, then the committee should cooperate to that extent. Now of course directors come and directors go, and one director may figure out a program at one particular time which does not fit the situation a couple of years later. I do not know why the Marlette Hospital, for instance, was not included in the program in 1948.

Perhaps the Director at that time felt that Marlette and the people connected with that project could raise sufficient money to complete it and for that reason it may have been done. I do not know just why it was not included, but regardless of why it was not included, today we find that two-thirds of the money necessary to complete this hospital has already been invested in this project and now it is standing idle and they cannot go ahead with it and the present Director says he would like to finish it and would like to have it included in here. Perhaps the answer would be to have a separate bill to include projects like these and where your Department would work along with the State directors and submit a favorable report to the Congress on these projects.

Dr. DEARING. They could be handled on the project basis.

Mr. SADOWSKI. Then we would not have to molest the basic law.

Dr. DEARING. They could be handled on the project basis, as you say, without changing the law.

Mr. SADOWSKI. I am satisfied if you are satisfied that you feel kindly toward the idea and you would want to work something out.

Dr. DEARING. We want very much to have the problem solved.

Mr. SADOWSKI. That is 90 percent of the solution of the problem, I imagine.

Dr. DEARING. We want to see the problem solved and we want to see the hospital beds where they are needed and we want to see the worthy projects completed.

Mr. SADOWSKI. Thank you.

Mr. PRIEST. Mr. Wilson, do you have a question?

Mr. WILSON. Mr. Chairman, I regret very much that I was not able to be present at the outset of Dr. Dearing's testimony but by reason of the fact that early this morning I went down to the airport and, with others of the Oklahoma congressional delegation, met Sir Alexander Fleming, the discoverer of penicillin, who is now en route to Oklahoma to dedicate the $3,000,000 research institute being dedicated down there this week end, I was somewhat delayed in arriving.

Mr. PRIEST. Under such auspicious circumstances you are excused for not being present.

Mr. WILSON. Thank you, sir.

I wanted to ask if Dr. Dearing had an opportunity to explain to the committee the technical amendments that I see he has suggested under appendix 2 of the brief that he has prepared here. Have you had an opportunity to discuss those or comment upon them?

Dr. DEARING. Only what I said in my prepared statement which is in the front, simply really listed them. The statement begins on page 12 and I simply listed what they referred to.

Mr. WILSON. I have had some opportunity, with all this discussion going on, to read your statement. I am wondering if good purpose might be served in our record if they were available for the entire membership of Congress to have some discussion about these amendments, at least in brief here. I observed them and I believe there are some very worthy ones, particularly as to a floor and particularly as to the vesting of title and manner and number of applicants and so forth.

I think it would be well if we were given an opportunity to talk about those.

Mr. PRIEST. Very well, Mr. Wilson.

Mr. WILSON. I will ask questions if you prefer.

Dr. DEARING. I would be glad to first call your attention to the subheading under tab 2 which does give more ample discussion of all these amendments but I would be glad to comment verbally or answer questions, whichever you wish.

Mr. WILSON. Turn to page 2 under tab 2.

Dr. DEARING. Yes, sir.

Mr. WILSON. You have them in numerical order, the first having to do with the increase of minimum allotment.

Dr. DEARING. Yes, sir.

Mr. WILSON. I notice you advocate an increase of the minimum from $100,000 to $200,000?

Dr. DEARING. That is simply a technical matter and is consistent with the amendment which is made to the act, I think made last year, to establish a minimum of $100,000. It simply means that under the formula for allotments in the original act, certain States would bet les than $100,000. In other words, they might get $37,000 or $50,000, States like Nevada, for instance. That was such a small amount that they could do practically nothing with it. Congress did set last year a statutory floor of $100,000 when the total amount available was $75,000,000. This would simply be proportional if the total annual authorization is $150,000,000.

It would raise the floor, the minimum for these few States which under the formula would not get that much. It would guarantee a minimum $200,000 which is the same proportion to $150,000,000 as the $100,000 was to $75,000,000.

Mr. WILSON. That would be in line with increasing the Federal share from one-third to two-thirds?

Dr. DEARING. Yes, sir; and enable more projects to receive assistance.

Mr. WILSON. Now on your second one there, vesting of hospital title there, solely, underscoring solely, have you had considerable difficulty along that line?

Dr. DEARING. I would like to ask Dr. Hoge to respond to that.

Dr. HOGE. Yes, Mr. Wilson, we have had several cases where the applicant had a 99-year lease on a piece of property which for all practical purposes would be as good as owning the property in fee simple but technically under the act that does not satisfy the condition of the law.

Mr. WILSON. And the Surgeon General has had to decline approval in some instances because of that condition on title?

Dr. HOGE. I think we have had to decline as a result of those conditions and they had to make other arrangements, either purchase the property or something similar.

Mr. WILSON. That 99-year lease is practically tantamount to ownership and in other instances where Federal buildings are erected, they are permitted to be erected on 99-year lease basis?

Dr. HOGE. I understand that to be the case; certainly 99 years or even somewhat less would be satisfactory.

Mr. WILSON. Then I take it your suggested technical amendment here is to prevent a wider discretion on the part of the Surgeon General to either waive or soften the requirement in that regard precedent to the approval of the applicant?

Dr. Hoge. Yes, sir. In other words, to give the Surgeon General the right to use his judgment to determine what is a proper right to the property.

Dr. Dearing. A practicl right to the property, that is correct.

Dr. Hoge. A practical right to the property, that is correct.

Dr. Dearing. It would avoid a delay which we run into in this when the community has to go back and purchase the property. The least that can happen is a delay of several months and the project could be blocked if it were impossible to make these other arrangements.

Mr. Wilson. In your suggested No. 3, on page 3, requirements for filing applications, I notice there that it is not permissible to have two applicants under the present law?

Dr. Hoge. That is correct, sir, and it is not at all an uncommon practice for a county perhaps to own a hospital and to turn it over on a lease arrangement to a religious body, let us say, or some other group that is experienced in operating hospitals; that is a very commonly accepted practice throughout the country. It is very difficult to do that under the present act because of the continuing obligations that the original sponsor undertakes.

It would be much more flexible and workable if there could be a joint application between the county, let us say, if the county owned the hospital, and the religious body or some other body which was going to operate it.

Mr. Wilson. As a practical thing, can you envisage practical difficulties in permitting dual applicants?

Dr. Hoge. No; we cannot see any difficulties involved there. Another very common situation is where a county and a city combined wish to operate a hospital. There are several of those which operate throughout the country and again there is dual ownership.

Mr. Wilson. You find in many areas the cooperative spirit, the cooperative unions, farmers, and organizations of that order, wanting to do something along this line. Would that permit them then to have a union with the municipality or county organization and join up a cooperative organization among farmers and thus make an application and obtain the Federal aid?

Dr. Hoge. If I understand you correctly, I think it would. What it does is to allow two eligible applicants, either one of which would be eligible by itself, to join together as joint applicants.

Mr. Wilson. You believe that is a necessary thing in the administration of this to avoid delays and to get at the places where it is needed, particularly in the rural areas?

Dr. Hoge. Yes, sir; we feel that it would facilitate the program quite a lot.

Mr. Wilson. I do not understand, on page 5, item No. 4 and No. 5, what you are driving at there. Will you explain those?

Dr. Hoge. Item 5, you say?

Mr. Wilson. The purposes for which Federal grants may be used and the payment of Federal share direct to the applicant.

Dr. Hoge. Oh, yes. The present law requires the Federal money to be paid over to the State for transmission to the hospital, the only exception being where the State by constitutional prohibition is not able to do that.

Under those conditions we can pay the Federal money direct to the hospital. Now there have been several occasions where the State felt that there was no useful purpose served in their taking the money from the Federal Government and handing it on to the applicant; that it merely caused delays in bookkeeping.

On several occasions we have been asked, would it not be possible for us to pay the money directly to the applicant and we think that where the State wishes it handled that way, that we should do it. It really saves them bookkeeping and delays in transmitting the checks.

Mr. WILSON. Dr. Hoge, if that came about, permitting direct payment in cases other than where there is a State constitution prohibiting, would that bring on a criticism that the Congress was circumventing the local State administration?

Dr. HOGE. Well, we still could not pay it direct to the applicant except by the request of the State.

Mr. WILSON. By request?

Dr. HOGE. Yes, sir.

Mr. WILSON. Which would be tantamount to going through State channels?

Dr. HOGE. Yes, sir; I think it would.

Mr. WILSON. Do you think that would be a good practical arrangement in the administration of this act?

Dr. HOGE. Yes, sir; we do think so.

Mr. WILSON. When you come to No. 6, recovery of Federal funds under certain contingencies, the present law provides for reaching out and recouping or recapturing certain funds on the basis of present value in the event the project is completed and then is to be operated by other than a nonprofit organization, as I understand it?

Dr. HOGE. That is correct. A number of hospitals wish to borrow funds from banks or insurance companies, and this provision somewhat clouds the value of the mortgage because the language seems to indicate that the Government might recover either from the original owner or the second owner, which would be the mortgage company, and for that reason it has been very difficult to get mortgage loans.

Mr. WILSON. The private lending agencies take the view that it might impair their security?

Dr. HOGE. That is correct.

Dr. DEARING. Some have taken the view that in the event of the recovery it does constitute a lien which impairs the standing of their mortgage.

Mr. WILSON. Whether it does or does not, it probably has not been determined in a court of competent jurisdiction?

Dr. HOGE. That is right.

Mr. WILSON. In your administration of this act, thus far, have you had cases where the applicant has been delayed in its progress on a particular project because it could not finance it to the extent necessary with the State two-thirds?

Dr. HOGE. Yes, sir; there have been cases of that kind.

Mr. WILSON. It has actually caused the project to cease to go forward?

Dr. HOGE. Either ceased to go forward or there were delays while they sought to get other funds.

Mr. WILSON. We cannot conceive of a private lending agency advancing funds where it is going to have difficulty in the event of involuntary foreclosure?

Dr. HOGE. That is correct.

Mr. Wilson. This in my mind, Mr. Chairman, is important because, in the event of the necessity of geting funds other than Federal aid, it would present a serious problem. I suggest that in a technical amendment there could be provided a waiver, an express waiver on the part of the law in the event the Surgeon General so determines.

Dr. Hoge. The present suggested amendment places the liability for repayment to the Government on the original owner and not on the second owner. So, in that way, the mortgage is not impaired; the security is not impaired.

Mr. Wilson. That is the suggestion?

Dr. Hoge. Yes, sir.

Mr. Wilson. Can you perceive of any practical reason why the Government should not in effect have a waiver in favor of the private lender in the event of a necessary involuntary foreclosure?

Dr. Hoge. No, sir; I have no answer to that.

Mr. Wilson. I believe you have one other suggestion on page 8, No. 7, "Authorization of appropriation and contractual obligation." Do we have any further comments on that?

Dr. Hoge. The present act contemplates annual appropriations in the full amount. The appropriation acts have, in effect, each year amended the basic act so as to provide contractual authorization. We felt that it would be a little cleaner deal if the contractual authorization was written into the basic act. Practically, it has not been a problem at all.

Dr. Dearing. But it has had to be carried annually in the appropriation act.

Mr. Wilson. In appendix B, you have a number of charts which show visually what you are trying to say there: the widespread authorization and the encumbering contracts incurred to the Government?

Dr. Dearing. Yes, sir.

Mr. Wilson. I am trying to show in the record the true picture, and that is why I am trying to get your comments. These pictures tell the story pretty clearly.

Dr. Dearing. The time the funds are encumbered is when the project is originally approved as meeting the requirements of the State plan.

Mr. Wilson. Both the State plan and by the Surgeon General?

Dr. Dearing. Yes, sir. Then the time when the funds are actually expended is months later, because the money is not paid until the project is actually under construction and so on.

Mr. Wilson. That is all I have to say except this one comment. I see on page 4 of Dr. Dearing's statement, which I think ought to be emphasized, "The State plans estimate that to provide adequate health care to the population an additional 897,000 beds would be needed."

The present law provides for only 90,000 during the course of a 5-year program, which would be only about 10 percent of the additional beds needed. To my mind, that emphasizes the practical need for the increasing of this program, Mr. Chairman.

Mr. Priest. I quite agree with you, and may I state that we had previously emphasized that same point, and I am glad to have the gentleman from Oklahoma emphasize it again.

Are there any other questions?

Mr. Bennett. Yes. I have one or two questions.

Mr. Priest. You may proceed.

Mr. Bennett. Carrying this just a little bit further: The necessity for additional beds. Evidently, according to your statement there is only 50 percent of the number of hospital beds in the country today that are actually needed. Is that what we may conclude from your statement?

Dr. Dearing. That is correct, sir, based on the minimal standards for the various types of hospital beds, specifically set forth in the bill: namely, general hospital, mental, tuberculosis, and chronic beds. This includes all beds, not simply general-hospital beds.

Mr. Bennett. Under the program suggested here, it would take 50 years from now to satisfy the present requirements?

Dr. Dearing. You mean at the rate——

Mr. Bennett. At the rate provided for at the present time—I mean at the rate provided for under the accelerated program of $150,000,000 a year—it would take 50 years to get the beds that you need today. Is that not true?

Dr. Dearing. I believe that is how it works out, perhaps a little less time than that.

Mr. Priest. Will the gentleman yield?

Mr. Bennett. Yes.

Mr. Priest. Perhaps this would be a factor there in determining the $150,000,000. It is provided that those would be Federal funds that would have to be matched and would that not cut down the number of years?

Dr. Dearing. I was going to say, sir, that that is assuming that this is the only way in which we go forward, but we know that hospitals are built, and we feel obviously that they should be built, outside of this program and that this is not the only method by which we can approach our goal.

Mr. Bennett. Of course, this method does discourage other types of private building; does it not? When people feel that they can get a hospital built by putting up one-third of the money and the Federal Government will put up the other two-thirds?

Dr. Dearing. We are now working in the top 10 percent on priority, and this would permit us to work on the top 20 percent of priority. The remainder can see pretty clearly that they had better find their own way.

Mr. Bennett. That is all.

Mr. Priest. Any further questions?

Mr. Wilson. Mr. Chairman, may I ask Dr. Dearing this question: Does the present law permit the Surgeon General to go behind the State plan and determine whether or not the State organization is giving a proper priority to the various areas, either regional or local?

Dr. Dearing. Only, Mr. Wilson, in what might be called a veto power. He cannot go in and rewrite the State plan. He can merely disapprove it. If the State plan does not appear to be sound or has not established priorities in a reasonable way as required by the regulations, he may disapprove the State plan. He does not go in himself or through representatives conduct an independent investigation.

Mr. Wilson. Should he disapprove, then it requires further action on the State level to be adjusted in keeping with his advice and counsel?

Dr. Dearing. That is right.

Mr. Wilson. Then, again, if the law is broadened to give him wider discretion, it will not only expedite them but cause more of them to be approved?

Dr. Dearing. That is right.

Mr. Priest. Mr. Biemiller?

Mr. Biemiller. Does that mean that, after a State plan has been accepted, the Surgeon General has, at the moment, no indirect power?

Dr. Dearing. Indeed he does, because then he must approve each individual project for conformity with the plan and regulations.

Mr. Biemiller. On the question of individual projects, is there any way that he can overrule the decision of the State officials as to priority?

Dr. Dearing. I believe not, sir, except if it is not in accordance with the plan which he has previously approved. If the State took a project that was way down in priority and submitted that when there are projects of higher priority, then he would disapprove that because it was not in accordance with the State plan.

Mr. Biemiller. But he cannot question the judgment of the State officials in placing a proposed project in A, B, C, or D category?

Dr. Dearing. Only when he has the whole plan under review. At that time he can question it; but, once he has reviewed the plan, it stands until revised by the State, and it is required to be revised and resubmitted and therefore approved once a year.

Mr. Biemiller. Once a year?

Dr. Dearing. That is correct.

Mr. Wilson. He can make additional surveys and studies despite the statutory requirement of July 1?

Dr. Dearing. That is right. The State can revise its plan at any time, and they are required to revise it annually. Each revision, of course, must be approved by the Surgeon General.

Mr. Wilson. Let me ask one further question, and then I will be through. Why is it—and I emphasize that—that a great number of these priorities are already approved by the State plans and are not able to make use of this Government aid?

Dr. Dearing. Because of the local-Federal share which requires that the community or somebody besides the Federal Government find $2 for every dollar that the Federal Government puts in.

Mr. Wilson. Thank you.

Mr. Bennett. The Surgeon General then has one veto, as I understand it, and that is the over-all plan that is submitted by the State once a year?

Dr. Dearing. He really has two, sir, one on the State plan as a whole and the second on each project.

Mr. Bennett. But, if he approves the State plan, then his veto is limited to whether the particular hospital under the State plan meets the specifications as described in the State plan?

Dr. Dearing. And whether it is in conformity with the State plan and whether it is an adequate safe structure.

Mr. Bennett. Does the Surgeon General have arbitrary veto power over the State plan? In other words, if the State of Michigan submits a plan for this fiscal year and he says, "Well, I do not like that plan," is that the end of it?

Dr. Dearing. The statute prescribes the certain conditions which the State plan must meet, and the Surgeon General must approve if it meets these conditions. There are guide lines in the statute, and the State can appeal to the Federal Hospital Council if its plan is rejected.

Mr. BENNETT. On a particular project, there is no appeal then?

Dr. HOGE. Not to the Surgeon General.

Mr. BENNETT. Once the State plan is approved and the Surgeon General vetoes a particular project under that plan, the veto is final?

Dr. HOGE. The State may appeal to the Surgeon General, in behalf of the applicant; that is what it amounts to.

Mr. BENNETT. When the Surgeon General makes the decision, that is final?

Dr. HOGE. Not necessarily so. Any decision might be revised, but the law provides that, should the Surgeon General disapprove a project, the State may request a hearing with the Surgeon General to discuss it. That has never happened.

Mr. BENNETT. If he turns it down, what happens then?

Dr. HOGE. Then the State can appeal to the United States Circuit Court of Appeals.

Dr. DEARING. There has never been an appeal on a project. That, I think, speaks for itself as regards the practical administration of the program.

Mr. BENNETT. I was just trying to find out what the procedure was and what the rights were.

Mr. PRIEST. If there are no further questions, we thank both of you doctors and others who have assisted you for your appearance today.

Dr. DEARING. Thank you for the opportunity to make this statement, sir.

Mr. PRIEST. Our next witness is Mr. George Bugbee, Executive Director of the American Hospital Association.

STATEMENT OF GEORGE BUGBEE, EXECUTIVE DIRECTOR, AMERICAN HOSPITAL ASSOCIATION

Mr. PRIEST. Mr. Bugbee, we welcome you before this committee again. You were helpful to the committee in drafting the original act and we are happy to have you here as a witness today.

Mr. BUGBEE. Mr. Charman, it is kind of you to say that and it is also kind of you to give me this opportunity to speak here.

The clerk has informed me that time presses and I would like to have the privilege of filing my entire statement. I will try to read the high spots, skipping portions of it in the interest of saving time, although we did try to put in only information that has some bearing on the problem before you.

Mr. PRIEST. Very well, the entire statement will be included in the record.

(The statement is as follows:)

STATEMENT OF GEORGE BUGBEE, EXECUTIVE DIRECTOR AMERICAN HOSPITAL ASSOCIATION

Mr. Chairman and members of the committee, it is a privilege to appear before you to make some recommendations and to comment on the proposals before your committee which would extend and expand the hospital survey and construction program.

I think the American Hospital Association needs very little explanation to this committee. Our 4,000 institutional members include hospitals of all types in every part of the country. These members include more than 85 percent of all of the general hospital beds of the Nation and more than half of the beds in hospitals operated by units of Federal, State, and local governments. We are also closely affiliated with the hospital associations of each State which have had a great deal to do with the effective accomplishments of the Hospital Survey and Construction program thus far.

The American Hospital Association presented testimony before committees of both House and Senate in support of the Hospital Survey and Construction Act a few years ago. The association helped in large measure to develop principles which were incorporated in that legislation. We believe that this program, which so sweepingly effects hospital care in the country, is the most significant health measure passed by Congress in recent years. In general we believe that the program has accomplished the aims of Congress in surveying present hospital facilities, in establishing a pattern of hospital facilities to serve all of our citizens, and in assisting, through Federal grants-in-aid to the States, in the construction of the most needed hospitals as determined by these objective surveys.

Some time before the enactment of this legislation the American Hospital Association inaugurated the Commission on Hospital Care, an independent, national body to study the hospital facilities and needs of the Nation. That commission pointed out the need for voluntary and governmental groups in all States to survey their existing physical facilities for rendering hospital care. The commission had contact with many of the independent surveys which were going on in some States before Congress approved the Hill-Burton Act. The commission was able to provide active assistance to some of the State agencies in carrying out the surveys provided under this Federal law.

As this association emphasized in its original testimony, the survey features of the Hospital Survey and Construction Act are almost as important as the Federal aid for hospital construction. We must bear in mind that much hospital construction is going on without Federal assistance. But we believe that in general even this independently planned construction is following the pattern established by the State studies which were encouraged and assisted by the hospital survey and construction program. These studies have been particularly valuable in pointing out the need for an integrated hospital system in which geographical areas might develop complete hospital services through cooperation between larger base hospitals and outlying smaller units. The surveys have done a great deal to make us conscious of the need for development of this method of improving hospital care and to give initial impetus toward its accomplishment.

It should be emphasized that the hospital survey and construction program has been outstanding among grant-in-aid programs because of the amount of cooperation which has been developed between existing voluntary agencies in the hospital field and State agencies charged with the responsibility of making surveys and developing State plans. Much of this cooperation stems from the basic legislation which has required that the States be provided maximum freedom in developing their own programs. Much of this cooperation is due to the fine administration of the program at the Federal level by Federal officials who have appreciated the spirit of this program and who have recognized the value of developing voluntary effort and utilizing such voluntary activity to the fullest extent. This unusual willingness on the part of governmental agencies to accept assistance and advice has been matched by the voluntary groups and the existing hospitals in the states and communities. This has been one of the most worthwhile domestic programs of the Federal Government because Washington has not insisted on performing the whole program; we have been able to enlist the eager efforts of all groups toward the improving of the hospital facilities of the Nation.

The American Hospital Association has played no small part in developing this cooperation with State and Federal agencies. The association has encouraged two annual conferences of State survey directors held concurrently with its conventions. Further, the association, in cooperation with the Public Health Service, conducted four regional conferences in which representatives of State agencies were brought together with representatives of State hospital associations to discuss the problems arising under the program. These regional conferences included representatives from practically every State and enabled State agencies to discuss their problems not only with leaders in the hospital field in their own State but also with State directors and hospital leaders from neighboring States. This sort of voluntary activity develops a cohesion and a spirit of common effort that cannot be brought about by mere regulation.

The staff of the American Hospital Association has been called on from time to time by many of the State agencies for participation in State surveys and in other cooperative projects which further the over-all intent of the hospital survey and construction program. And, as I have said, there has been a high degree of cooperation between the State agencies and State hospital associations in making this program effective.

In passing, it is important to note that one of the byproducts of the Hospital Survey and Construction Act has been the improvement in hospital design. A large volume of planning under this program has provided an excellent incentive for study. However, mention must be made of the excellent technical recommendations coming from the architectural section of the Hospital Facilities Division of the Public Health Service. In addition many conferences have been held throughout the country with architects interested in hospital design. Without any question, hospital design country-wide is at the highest level of quality ever obtained.

Surprisingly few faults have been found in the Hill-Burton Act as enacted by Congress. This is unusual when it is remembered that this program is a venture in a new area for the Federal Government. It is a tribute to the care with which the legislation was studied and molded by the subcommittee on Health of the old Committee on Education and Labor of the Senate 3 years ago. The long hours and arduous study of that group have been amply justified in the proven excellence of the legislation as a whole. This program has been widely acclaimed and has had a minimum of criticism.

As might be expected in any program which allows considerable latitude to the States there is a natural variation in State performance. But much is being accomplished even in those States which have not done as much as others. And in a number of outstanding instances, the administrative talent of the State agency, plus an unusual degree of cooperation between State agency personnel, local and State hospital groups, and the general public, have produced unusual progress. In these States they have not only done a great deal in providing additional hospital facilities but they have been able to develop patterns upon which great improvement in over-all health facilities in the State can be advanced.

We believe that, if this act is to be amended in the general manner suggested in H. R. 2176, there is need for prompt action. There is danger that approval and consideration of individual projects may be delayed until local communities and State agencies are sure as to the amount of Federal money available and the percentage to be required from State and local funds. Therefore, it is imperative that Congress promptly enact such amendments as may be desirable so that the program may not be greatly delayed.

INCREASED APPROPRIATIONS

H. R. 2176 recommends that the annual appropriation be increased from $75,000,000 to $150,000,000. Originally Congress reduced the amount from $100,000,000 to $75,000,000. There are good reasons now for increasing the annual appropriation. Cost of hospital construction has markedly increased since the enactment of Public Law 725. However, the surveys reported to this committee by the Public Health Service indicate that even an appropriation of $150,000,000 per year for the period of time suggested will not by any means provide all the hospital facilities that the Nation needs.

We should bear in mind that the mere construction of hospital facilities does not automatically result in hospital service. Trained personnel can be provided only at a given rate, and facilities should not be constructed more rapidly than personnel can be developed. And there is a tendency to use Government funds to construct facilities which are not always supported by adequate Government assistance in providing for those unable to meet the cost of hospital care.

The over-all need to be met by an increased appropriation will be effected by the proportion of State and local funds in each project. If the percentage of Federal participation is increased, total construction will necessarily be reduced, as I shall presently explain.

The American Hospital Association approves the increase in annual authorized appropriations to $150,000,000.

EXTENDED TIME

H. R. 2176 suggests that the act be amended so as to be in effect through June 1955. It is obvious from the outline of need shown by the State surveys that annual appropriations through that date will be wise. The American Hospital

Association approves the extension of the period of effectiveness of this legislation.

We further recommend that Congress review the legislation periodically to make such extensions or revisions of the law as experience may indicate. However, we believe that extension beyond that suggested in this proposal would be unwise at this time.

FEDERAL PERCENTAGE

H. R. 2176 recommends a variable Federal percentage which provides that the poor States may contribute a lesser proportion of State and local money. The poorer State would be required to match $3 of Federal money with $1 of State and local money; the wealthiest State would be required to match $1 of Federal money with $2 of State and local money. The variations would be determined according to the average per capita income in each State.

The Senate subcommittee, which originally studied this legislation, spent weeks considering the variable-percentage principle. The bill, as passed by the Senate, provided for the individual project percentage now incorporated in H. R. 2176.

The deficits in hospital facilities correlates very closely with income within each State and that the percentage recommended closely follows the need for facilities. However, a very important consideration for this committee is the reduction in total construction which may result from a reduced requirement for State and local funds. Some illustration of that reduction may be warranted.

At the present time a State having a Federal allotment of $3,000,000 must put up twice as much State and local money to provide a total construction of $9,000,000. If the over-all appropriation is doubled, the poorest State with Federal percentage of 75 percent would have a total allotment of $6,000,000 which would then be matched with only $2,000,000 providing a total construction fund of only $8,000,000. If the Federal percentage were 50 percent, total construction in the same State would be $12,000,000. If the Federal percentage were 40 percent, total construction would be $15,000,000. These figures must be considered, bearing in mind that if the Federal percentage remains at 33⅓ percent, the same State with an increased allotment equaling $6,000,000 would construct, $18,000,000 in total hospital facilities.

There is an unresolved question as to the difficulty that communities are experiencing in raising the non-Federal share of funds for hospital construction. Examination of those projects which have been approved to date would clearly indicate that Federal funds have gone to high priority projects. It is true that some areas have difficulty in raising funds. Yet the American Hospital Association is fully convinced of the need for a demonstration of local initiative in the raising of funds if the hospital is to be successfully operated. The raising of funds not only demonstrates community interest but requires the existence of a community organization which may do much to assure the successful operation of the hospital once it has been built. It has been estimated that it costs one-third as much to maintain and operate a hospital for 1 year as it does for original construction. It would be a disservice to a community to build in it a hospital which is not prepared to maintain so as to provide a high quality of care to its citizens.

The board of trustees of the American Hospital Association, having considered this matter, has recommended that the Federal percentage be increased for all States from the present 33⅓ percent to 40 percent.

RESEARCH AND DEMONSTRATIONS IN HOSPITAL INTEGRATION

The American Hospital Association endorses the section of H. R. 2176 which would provide funds to the Public Health Service for projects for the conduct of research, experiments or demonstrations relating to the development, utilization and coordination of hospital services, facilities and resources. Your committee has already heard statements from able witnesses as to independent projects of this nature which have been developed under voluntary auspices in several sections of the country.

Integration of hospital facilities in geographic areas has had increasing attention in recent years. The American Hospital Association recognized this in its 1944 statement of principles for providing hospital services to the American people. Extension of interhospital coordination and cooperation, both urban and rural, is one of the association's avowed aims.

As has been pointed out to your committee, these programs are primarily a problem of education and the establishment of effective patterns. We believe that the Public Health Service may render a substantial service to the hospital field and to the national community by the studies and research projects which are envisioned by this proposal. It is essentially in keeping with the adopted policies of the American Hospital Association.

STATE AGENCY ADMINISTRATION

It has been proposed that the Federal Government should share in the cost of administration of the hospital survey and construction program in each State. This proposal is not new. It appeared in the original legislation introduced in Congress. After serious consideration by the Senate Committee on Education and Labor it was rejected.

The American Hospital Association believes that the States can and should provide adequate funds for administration of State agencies. However, there is evidence that some State legislatures have not made adequate appropriations and as a result do not have an administrative staff which can satisfactorily carry out the terms of the Federal legislation.

An alternate proposal in H. R. 2176 suggests that the agencies be required to provide a certain percentage of total funds expended for State administration in order to participate in the Federal grants. However, we are inclined to believe that the percentage shown in H. R. 2176 is unrealistic. Further, it is questionable that any definite percentage of either the over-all funds expended in the State or the Federal funds granted to the States can be established in such a manner as to provide a reasonable basis for measuring the need for administrative expenditures. Therefore, we suggest striking the parenthetical material in section 4 which will permit the administrator of the act to withhold assistance from a State which has obviously not met its administrative responsibilities.

VARIATION OF FEDERAL PERCENTAGE IN INDIVIDUAL PROJECTS

It has been suggested to this committee that the State agencies be given authority to vary the percentage of Federal funds between projects within the State. We recognize that special conditions in a very few States make it possible to establish an objective formula by which such variation could be accomplished in an impartial manner. But in practically all of the States such a provision would immediately expose State agencies to pressures unrelated to the objective needs of various communities. Public Law 725 was carefully written to avoid undue political pressure on the State agency by having the location of hospitals determined according to impartial surveys and the Federal proportion fixed according to a mathematical formula. The result has been a remarkable absence of political pressure in a building program which could so easily be susceptible to improper influence. If we could be sure that the variation in the State would be determined according to existing factual data relative to economic need and on a basis which would be completely objective, the suggestion for additional flexibility would have great merit. The difficulty is that only few States are organized and have such data so as to make this determination objectively.

On the other hand, several States have provided State appropriations which supplement the Federal contribution. There is nothing to prevent the State itself from providing its own funds on a variable basis according to information which it might have available concerning its areas of varying economic need. Some States have been able to do this successfully.

However, the strongest argument for such flexibility has been the contention that individual projects often needed less than the one-third Federal contribution. We believe that this problem is being met on a very practical basis by dividing projects into separate parts with the Federal grant being allocated to only one part of the project. Or we would not have serious objection to permitting States to approve applications for a Federal percentage of participation below the fixed Federal percentage established by law for that State.

RETROACTIVE CLAUSE

It has been suggested that amendments in the Federal percentage be made retroactive to the original date of enactment of the Hospital Survey and Construction Act. We are not in position to make constructive comment on this suggestion. We can see that a retroactive provision could result in major confusion. On the other hand in many instances where the cost of the project has increased as a result of higher construction cost, a higher Federal percentage might be very helpful. It is probable that this issue must be decided on the basis of precedent in other Federal legislation. With this in mind our primary emphasis would be on the need for early decision by Congress so that the issue may not be left too long in uncertainty.

GENERAL COMMENTS

It is worth reemphasizing that the projects so far approved under Public Law 725 of the Seventy-ninth Congress have been in areas of high priority of need. We believe that Congress should periodically review this program and take into consideration the success which local areas are having in raising their proportions of the cost of construction.

In speaking of the high level of cooperative effort which has been developed under this program we wish to point out that one of the outstanding contributions to the success of this program has been the establishment of the Federal Hospital Council with the authority granted to it under this law. In our judgment it has been a constructive force in the development of the administration of this program. But it has also been an assurance to the hospital field as a whole that in the development of this program the Federal Government would not attempt to impose arbitrary new patterns upon the existing system. As a matter of fact. because of the responsibility and authority entrusted to this council, it has been able, because it is truly representative of the hospital field and the consumers of hospital care, to strengthen the hand of the Surgeon General in establishing regulations and administrative procedure. We are sure that inquiry to the Surgeon General and others of the Public Health Service directly concerned with the administration of this act will confirm the constructive contribution of the Federal Hospital Council as presently constituted. The Surgeon General has made good use of this council and it has not failed its responsibilities. The major success of this whole program to date is a testimonial to the cooperation that has been developed at the Federal level between governmental and nongovernmental groups and, as I have said, this cooperation has been reflected at all levels of administration.

Recommendations have been made that special priority be given to facilities for group practice and that cooperatives be given added priority. These are well-intentioned proposals. However, your committee will wish to study very closely the effect of granting such priorities. Both types of projects are now eligible for grants. But, in view of the over-all aims of the legislation, we do not believe that special priorities should be given to any groups under this program. If such agencies need special support, it should be done in some other way than through special consideration in hospital-facility construction.

H. R. 4763, introduced by Mr. Poulson, of California, suggests that special priorities be granted to areas which have had great increase in population during recent years. Some of these special needs were met under the Lanham Act for community facilities, which provided hospitals in some areas during the war. There are areas, particularly on the west coast, where a major increase in population has greatly exceeded the local communities' ability to provide hospital facilities. State plans should reflect these special community needs, and we believe that this problem should be given consideration by your committee.

SUMMARY

The American Hospital Association recognizes that the hospital survey and construction program is making great contributions toward the establishment of proper hospital facilities for the Nation. While much has been done, much needs to be done and the program has only begun.

Accordingly the American Hospital Association supports the over-all recommendations for amendment to the Hospital Survey and Construction Act as embodied in H. R. 2176 with the exception that it recommends restudy of the requirements for minimum appropriations for State administrative agencies and suggests that the Federal percentage for all States be uniformly increased from the present 33⅓ to 40 percent.

In general, Mr. Chairman, we believe that the Hospital Survey and Construction Act can be considered one of the most worthwhile domestic programs the Federal Government has ever undertaken. The American Hospital Association is proud to support it.

Mr. Bugbee. Mr. Chairman, I shall skip over the first page which tells something of the background of the association that I represent and I will go on to the middle of page 2.

As this association emphasized in its original testimony, the survey features of the Hospital Survey and Construction Act are almost as important as the Federal aid for hospital construction. We must bear in mind that much hospital construction is going on without Federal assistance. But we believe that in general even this independently planned construction is following the pattern established by the State studies which were encouraged and assisted by the hospital survey and construction program. These studies have been particularly valuable in pointing out the need for an integrated hospital system in which geographical areas might develop complete hospital services through cooperation between larger base hospitals and outlying smaller units.

The surveys have done a great deal to make us conscious of the need for development of this method of improving hospital care and to give initial impetus toward its accomplishment.

It should be emphasized that the hospital survey and construction program has been outstanding among grant-in-aid programs because of the amount of cooperation which has been developed between existing voluntary agencies in the hospital field and State agencies charged with the responsibility of making surveys and developing State plans.

Much of this cooperation stems from the basic legislation which has required that the States be provided maximum freedom in developing their own programs. Much of this cooperation is due to the fine administration of the program at the Federal level by Federal officials who have appreciated the spirit of this program and who have recognized the value of developing voluntary effort and utilizing such voluntary activity to the fullest extent.

Mr. Chairman, I will now skip over to page 4 in the second paragraph.

In passing, it is important to note that one of the byproducts of the Hospital Survey and Construction Act has been the improvement in hospital design. A large volume of planning under this program has provided an excellent incentive for study. However, mention must be made of the excellent technical recommendations coming from the architectural section of the Hospital Facilities Division of the Public Health Service.

In addition many conferences have been held throughout the country with architects interested in hospital design. Without any question, hospital design country-wide is at the highest level of quality ever obtained.

Surprisingly few faults have been found in the Hill-Burton Act as enacted by Congress. This is unusual when it is remembered that this program is a venture in a new area for the Federal Government. It is a tribute to the care with which the legislation was studied and molded by the Subcommittee on Health of the old Committee on Education and Labor of the Senate 3 years ago, and by the committee of the House.

The long hours and arduous study of that group have been amply justified in the proven excellence of the legislation as a whole. This program has been widely acclaimed and has had a minimum of criticism.

We believe that, if this act is to be amended in the general manner suggested in H. R. 2176, there is need for prompt action. There is danger that approval and consideration of individual projects may be delayed until local communities and State agencies are sure as to the amount of Federal money available and the percentage to be required from State and local funds. Therefore, it is imperative that Congress promptly enact such amendments as may be desirable so that the program may be not greatly delayed.

Then the next section on "Increased appropriations"—I will skip the first paragraph and go to page 6.

We should bear in mind that the mere construction of hospital facilities does not automatically result in hospital service. Trained personnel can be provided only at a given rate, and facilities should not be constructed more rapidly than personnel can be developed. And there is a tendency to use Government funds to construct facilities which are not always supported by adequate Government assistance in providing for those unable to meet the cost of hospital care.

The over-all need to be met by an increased appropriation will be effected by the proportion of State and local funds in each project. If the percentage of Federal participation is increased, total construction will necessarily be reduced, as I shall presently explain.

The American Hospital Association approves the increase in annual authorized appropriations to $150,000,000.

Extended time: H. R. 2176 suggests that the act be amended so as to be in effect through June 1955. It is obvious from the outline of need shown by the State surveys that annual appropriations through that date will be wise. The American Hospital Association approves the extension of the period of effectiveness of this legislation.

We further recommend that Congress review the legislation periodically to make such extensions or revisions of the law as experience may indicate. However, we believe that extension beyond that suggested in this proposal would be unwise at this time.

Federal percentage: H. R. 2176 recommends a variable Federal percentage which provides that the poor States may contribute a lesser proportion of State and local money. The poorer State would be required to match $3 of Federal money with $1 of State and local money; the wealthiest State would be required to match $1 of Federal money with $2 of State and local money. The variations would be determined according to the average per capita income in each State.

The Senate subcommittee, which originally studied this legislation, spent weeks considering the variable percentage principle. The bill, as passed by the Senate, provided for the individual project percentage now incorporated in H. R. 2176.

The deficits in hospital facilities correlate very closely with income within each State and that the percentage recommended closely follows the need for facilities. However, a very important consideration for this committee is the reduction in total construction which may result from a reduced requirement for State and local funds. Some illustration of that reduction may be warranted.

At the present time a State having a Federal allotment of $3,000,000 must put up twice as much State and local money to provide a total construction of $9,000,000. If the over-all appropriation is doubled, the poorest State with Federal percentage of 75 percent would have a total allotment of $6,000,000 as compared with the $3,000,000, which would then be matched with only $2,000,000 providing a total construction fund of only $8,000,000.

If the Federal percentage were 50 percent, total construction in the same State would be $12,000,000. If the Federal percentage were 40 percent, total construction would be $15,000,000. These figures must be considered, bearing in mind that if the Federal percentage remains at 33⅓ percent, the same State with an increased allotment equaling $6,000,000 would construct $18,000,000 in total hospital facilities.

There is an unresolved question as to the difficulty that communities are experiencing in raising the non-Federal share of funds for hospital construction. Examination of those projects which have been approved to date would clearly indicate that Federal funds have gone to high priority projects. It is true that some areas have difficulty in raising funds.

Yet the American Hospital Association is fully convinced of the need for a demonstration of local initiative in the raising of funds if the hospital is to be successfully operated.

The raising of funds not only demonstrates community interest but requires the existence of a community organization which may do much to assure the successful operation of the hospital once it has been built.

It has been estimated that it costs one-third as much to maintain and operate a hospital for 1 year as it does for original construction. It would be a disservice to a community to build in it a hospital which it is not prepared to maintain so as to provide a high quality of care to its citizens.

The board of trustees of the American Hospital Association, having considered this matter, has recommended that the Federal percentage be increased for all States from the present 33⅓ percent to 40 percent.

Research and demonstrations in hospital integration: The American Hospital Association endorses the section of H. R. 2176 which would provide funds to the Public Health Service for projects for the conduct of research, experiments or demonstrations relating to the development, utilization and coordination of hospital services, facilities and resources.

I will skip the balance of that paragraph which documents the association's support of that.

State agency administration: It has been proposed that the Federal Government should share in the cost of administration of the hospital survey and construction program in each State. This proposal is not new. It appeared in the original legislation introduced in Congress. After serious consideration by the Senate Committee on Education and Labor it was rejected.

The American Hospital Association believes that the States can and should provide adequate funds for administration of State agencies. However, there is evidence that some State legislatures have not made adequate appropriations and as a result do not have an administrative staff which can satisfactorily carry out the terms of the Federal legislation.

An alternate proposal in H. R. 2176 suggests that the agencies be required to provide a certain percentage of total funds expended for State administration in order to participate in the Federal grants.

However, we are inclined to believe that the percentage shown in H. R. 2176 is unrealistic.

Further, it is questionable that any definite percentage of either the over-all funds expended in the State or the Federal funds granted to the States can be established in such a manner as to provide a reasonable basis for measuring the need for administrative expenditures. Therefore we suggest striking the parenthetical material in section 4, which will permit the administrator of the act to withhold assistance from a State which has obviously not met its administrative responsibilities.

Variation of Federal percentage in individual projects: It has been suggested to this committee that the State agencies be given authority to vary the percentage of Federal funds between the projects within the State. We recognize that special conditions in a very few States make is possible to establish an objective formula by which such variation could be accomplished in an impartial manner.

But in practically all of the States such a provision would immediately expose State agencies to pressures unrelated to the objective needs of various communities. Public Law 725 was carefully written to avoid undue political pressure on the State agency by having the location of hospitals determined according to impartial surveys and the Federal proportion fixed according to a mathematical formula. The result has been a remarkable absence of political pressure in a building program which could so easily be susceptible to improper influence. If we could be sure that the variation in the State would be determined according to existing factual data relative to economic need and on a basis which would be completely objective, the suggestion for additional flexibility would have great merit.

The difficulty is that only few States are organized and have such data so as to make this determination objectively.

On the other hand, several States have provided State appropriations which supplement the Federal contribution. There is nothing to prevent the State itself from providing its own funds on a variable basis according to information which it might have available concerning its areas of varying economic need. Some States have been able to do this successfully.

However, the strongest argument for such flexibility has been the contention that individual projects often needed less than the one-third Federal contribution. We believe that this problem is being met on a very practical basis by dividing projects into separate parts with the Federal grant being allocated to only one part of the project. Or we would not have serious objection to permitting States to approve applications for a Federal percentage of participation below the fixed Federal percentage established by law for that State.

Retroactive clause: It has been suggested that amendments in the Federal percentage be made retroactive to the original date of enactment of the Hospital Survey and Construction Act. We are not in position to make constructive comment on this suggestion. We can see that a retroactive provision could result in major confusion.

On the other hand in many instances where the cost of the project has increased as a result of higher construction cost, a higher Federal percentage might be very helpful. It is probable that this issue must be decided on the basis of precedent in other Federal legislation. With this in mind our primary emphasis would be on the need for early decision by Congress so that the issue may not be left too long in uncertainty.

General comments: It is worth reemphasizing that the projects so far approved under Public Law 725 of the Seventy-ninth Congress have been in areas of high priority of need. We believe that Congress should periodically review this program and take into consideration the success which local areas are having in raising their proportions of the cost of construction.

In speaking of the high level of cooperative effort which has been developed under this program we wish to point out that one of the outstanding contributions to the success of this program has been the establishment of the Federal Hospital Council with the authority granted to it under this law.

In our judgment it has been a constructive force in the development of the administration of this program. But it has also been an assurance to the hospital field as a whole that in the development of this program the Federal Government would not attempt to impose arbitrary new patterns upon the existing system.

As a matter of fact, because of the responsibility and authority entrusted to this council it has been able, because it is truly representative of the hospital field and the consumers of hospital care, to strenghen the hand of the Surgeon General in establishing regulations and administrative procedure.

We are sure that inquiry to the Surgeon General and others of the Public Health Service directly concerned with the administration of this act will confirm the constructive contribution of the Federal Hospital Council as presently constituted. The Surgeon General has made good use of this Council and it has not failed its responsibilities. The major success of this whole program to date is a testimonial to the cooperation that has been developed at the Federal level between governmental and nongovernmental groups and, as I have said, this cooperation has been reflected at all levels of administration.

Recommendations have been made that special priority be given to facilities for group practice and that cooperatives be given added priority. These are well-intentioned proposals. However, your committee will wish to study very closely the effect of granting such priorities. Both types of projects are now eligible for grants.

But, in view of the over-all aims of the legislation, we do not believe that special priorities should be given to any groups under this program. If such agencies need special support, it should be done in some other way than through special consideration in hospital facility construction.

H. R. 4763, introduced by Mr. Poulson, of California, suggests that special priorities be granted to areas which have had great increase in population during recent years. Some of these special needs were met under the Lanham Act for community facilities, which provided hospitals in some areas during the war. There are areas, particularly on the west coast, where a major increase in population has greatly exceeded the local communities' ability to provide hospital facilities. State plans should reflect these special community needs and we believe that this problem should be given consideration by your committee.

Mr. Chairman, I will skip the summary.

Mr. PRIEST. We thank you very much.

On the last point you mentioned, it is still your opinion that the question of giving special consideration to areas or groups might well be left with the State agency in developing its State plan rather than making any attempt by legislation to give that special consideration?

Mr. Bugbee. I think an effort is made to do that through the State plan. I am not sure that it meets the problem which has been particularly emphasized by hospital people in California, specifically, where in the Los Angeles area their population has increased way beyond the ability to provide facilities and yet as has been pointed out, construction under this act is such a small proportion of the total need that the construction in California has tended to go to the rural areas and therefore there has been no construction in the Los Angeles area and they felt there was need for Federal money.

I do not think it is simple to answer, Mr. Chairman. We have been urged to present that problem to you for your consideration.

Mr. Priest. Any questions, gentlemen?

Mr. Sadowski. No questions.

Mr. Priest. Mr. Bennett?

Mr. Bennett. Mr. Bugbee, we came to the conclusion earlier this morning that computing the allocation formula between the States required students of mathematical mind, but after the money is finally allocated to the State the Federal-State share is a little more susceptible to analysis by the average person.

Now I understood the Surgeon General to say that in determining what is to be spent on a project that as much as two-thirds of Federal money could be spent on a particular project and one-third contributed by the sponsor of the project. In other words, the local agency.

Mr. Priest. Will the gentleman yield?

Mr. Bennett. Yes.

Mr. Priest. I believe that is a proposal. That is not true under existing law.

Mr. Bennett. I understood the Surgeon General to say the formula was the same.

Mr. Priest. The proposed formula.

Mr. Bennett. I see what you mean. He said the allocation between the States formula is the same?

Mr. Priest. That is right.

Mr. Bennett. The Federal-State share, after the Federal allocation has been made is to be changed?

Mr. Bugbee. That is correct, I think, in all the legislation.

Mr. Bennett. What is your position on the changes in the Federal-State share as suggested by the Surgeon General here this morning?

Mr. Bugbee. As I tried to point out in the testimony, we are apprehensive of making the Federal share too great, Mr. Bennett, and we recommend a straight 40 percent for all States just as now the percentage of Federal money in each project is 33⅓ percent.

We recommend that that be increased to a flat amount of 40 percent as opposed to the proposals in other legislation before you which vary broadly. Well, it would take me quite a little while to describe them, but there are some that permit a flat amount for every project in each State and that percentage is the allotment percentage so that for the poorest State the Federal share would be 75 percent and for each State a varying amount, I think someone mentioned that for Michigan it was 43 percent, under that formula. But it would be a fixed formula to that State to apply to every application for that State.

Mr. Bennett. You are talking about two different things?

Mr. Bugbee. There are at least three distinct proposals before your committee. None of them changes the allotment percentage, Mr. Bennett, the percentage which determines the amount of money that each State gets. I think none of them changes that.

Mr. Bennett. All right.

Mr. Bugbee. But once the money is allotted there are at least three proposals before you as to how much of the Federal money shall be used in each project.

Mr. Bennett. Your proposal is this, if I understand it correctly, that in each case, within each State the Federal Government can contribute 40 percent, no less and no more for each hospital construction project?

Mr. Bugbee. Yes; and the same plan as is now in effect except that the percentage is increased from 33⅓ to 40 percent.

Mr. Bennett. Yes. The Surgeon General, if I understood him correctly, said they favored a plan whereby a particular State, after it had its allotment could, if it wanted to, spend as much as 66⅔ of the Federal money and require only 33⅓ percent of State or local funds for each project. I was wondering if you had any comment in connection with that?

Mr. Bugbee. I have great respect for the Surgeon General and his Department in administering this Department. However, I think this is a matter of trying to project what will happen under different circumstances so that I think he will not object if I say that my own judgment would be opposed to so generous an allotment to a local community at the present time. We must bear in mind that this is an act to provide facilities and that we have not yet, country-wide, provided a method for financing hospitals in all of the most needy areas.

Mr. Bennett. Do you think that if the law permitted the individual State to contribute only one-third and let the Federal Government contribute 66⅔; that is, within the discretion of the States, that it might result in construction of fewer hospitals around the country, having in mind that each State might gage its program with the 66⅔ contribution rather than with the one-third or 40 percent?

Mr. Bugbee. It not only constructs fewer hospitals, but it makes it relatively more easy for a community to secure a hospital. We are fully convinced that most communities can support a hospital pretty well if they organize, get community interest in supporting it, and are prepared to do the things needed to have a hospital in their community.

But, if they get the hospital very easily, we are inclined to think that there might be one large donor that would make up the one-third and they would have the hospital without any preparation to insure its operation. That argument goes along to whatever degree you increase the percentage and we are agreeing to some increase. The 66 seemed pretty high to us.

Mr. Bennett. That is all, Mr. Chairman.

Mr. Priest. Mr. Biemiller?

Mr. Biemiller. I wonder, Mr. Bugbee, if you would mind carrying just one step further the praise that you give to the functioning of the Federal Hospital Council in its relationship with the Surgeon General. Could you give us just one or two points as to why you think it has been successful—what the techniques have been?

Mr. BUGBEE. This act as originally written endeavored to spell out pretty exactly what the responsibility of the Administrator and the Surgeon General were in carrying out the purposes of the act, but it was in a new area, as I have mentioned, and not everything could be spelled out by any means and it left a rather broad area to be covered under regulations.

In the legislation, and there was some opposition to it at the time it was enacted, the hospital council was given authority to approve the regulations of the Surgeon General. At one stage one of the witnesses this morning described the membership of the Council, it is composed substantially of four technical and four public members. The regulations as they have come to the Council have in some instances been rather detailed. Those that apply to construction standards are detailed. But as I have said in the testimony, we believe that those standards have done a tremendous amount to improve the quality of hospital design.

However, the fact that they were approved by the Federal Hospital Council with the representation on that Council, it gave the Surgeon General backing in those regulations that would not have been possible otherwise and there have been a number of problems of bringing support of those who were affected by legislation that I think have been made much simpler by having the Council jointly responsible for the regulations.

Mr. BIEMILLER. In your opinion then, the entire act has functioned more successfully because you have had the prestige of the Council as well as the Surgeon General?

Mr. BUGBEE. Yes, sir.

Mr. BIEMILLER. By and large, in your opinion, have the relationships between the Surgeon General and the Council and his staff been harmonious?

Mr. BUGBEE. Unusually so.

Mr. BIEMILLER. You make a point toward the end of the testimony that as the law now stands there is nothing to prevent granting of priorities to group health clinics or cooperatives. Have any such grants been made?

Mr. BUGBEE. I could not tell you. I would point out that a hospital organized as a cooperative is not a common occurrence. The community nonprofit hospital is in a sense a cooperative but I believe that the proposal that is embodied in the legislation points toward a cooperative where there is a membership fee and governing of the hospital. I do not have up-to-date information but my last information was that there were only a limited number, perhaps a dozen countrywide. So that I do not know whether any one of those has been aided. If they wished to organize one in a needy area, there would be no reason why they should not be able to do so, but it would be on the basis of providing facilities in that area.

I see great advantage for providing cooperatives in certain areas but if facilities is their problem, they are eligible under this act.

Mr. BIEMILLER. Your contention is that the eligibility would be based purely upon need and not upon the type of organization?

Mr. BUGBEE. If the Congress wanted to stimulate the organization of cooperatives, I would not think that that aim should be superimposed on a hospital facility act, it is broader than that.

Mr. BIEMILLER. You would think, in other words, that if we were going to go ahead with a project of that sort that the general outline of title 4 of the omnibus bill which does set up formulas for that is a sounder approach than to tack it on as a rider to the Hospital Construction Act?

Mr. BUGBEE. Well, I would think it was sounder to have it in separate legislation. I have not studied with great care that section in the omnibus measure.

Mr. BIEMILLER. It is a separate unit with a separate administrative body and its relationship then to the Hospital Construction Act would be only incidental, rather than primary?

Mr. BUGBEE. Yes.

Mr. BIEMILLER. That is all, Mr. Chairman.

Mr. WILSON. Mr. Chairman?

Mr. PRIEST. Mr. Wilson.

Mr. WILSON. Might I suggest that Mr. Bugbee, in following further the questioning of my colleague, Mr. Biemiller, along the lines of groups or cooperatives, that Dr. Hoge may be able to give us some information at the moment as to whether applications have been presented or whether or not they had been approved.

Dr. HOGE. Yes, sir, Mr. Chairman; there have been.

I am quite sure that there have been some cooperative hospitals in Texas, if not elsewhere, approved under this program.

Mr. WILSON. And the construction is going forward?

Dr. HOGE. Yes, sir.

Mr. WILSON. Now, Mr. Bugbee, I was very much interested in the underlying reason for your judgment, your opinion, as to the increase of 33⅓ to 40 percent rather than to 50 percent or 66⅔ percent. Is it based entirely, or not entirely perhaps, but in the main, upon being too generous on the part of the Federal Government to raise it up to 50 percent or 66⅔ percent rather than 40 percent?

Mr. BUGBEE. No, I do not feel that way, Mr. Wilson; it is more from the standpoint that the hospital is a public-service agency. Under this act, they are organized and would be built dependent on public support to keep them operating as a satisfactory unit. It is a conviction on the part of our membership that that exercise of responsibility is to a degree related to the interest the community takes in providing a hospital.

Mr. WILSON. Mr. Bugbee, I believe you are dead right in that there must be that community initiative to go forward and maintain it, staff it, and operate it but as a practical matter, will that not seek its level? Will it not result as a practical thing in the fact that there will be greater construction than they can staff?

Mr. BUGBEE. Well, the law provides certain controls on that. For example, it provides that the community must give some evidence of being able to support the hospital before an application can be approved by the State agency and the Surgeon General so that there is that protection and perhaps that justified some increase above the 33⅓ percent. But construction, as I pointed out, the cost of a hospital is only about three times the annual support cost.

Mr. WILSON. One year's operation?

Mr. BUGBEE. Yes. So it is very important that they not go lightly into this business of building a hospital in a community. The 33⅓ percent, as I pointed out, has worked pretty well and the money has in general been used up to the amount allocated by Congress, it has been used for relatively high-priority projects and that does not seem to indicate a sharp increase as well as the problem of each increase reducing the number of beds constructed in total.

Mr. WILSON. Mr. Bugbee, if we use the example in dollars as shown in your statement in No. 7 and 8, of recommending the increase from 33⅓ to 40 percent, it would show on your particular figure as to $15,000,000 if the Federal percentage were 40 percent, total construction would be $15,000,000.

But you are referring there to a poorer State on a per capita income basis and if I figure that right, that would mean that the Federal Government would put up only $6,000,000 as against a local contribution of $9,000,000. As a practical thing, would it not be pretty nearly impossible for your lower-income States to ever arrive at that?

Mr. BUGBEE. They are doing even better than that with the annual allotments to date.

Mr. WILSON. Of one-third?

Mr. BUGBEE. The poorer States, you see, under the allotment tend to get a greater allotment than the wealthier States so that the poorer State gets—I cannot tell you the exact amount—but here are some States with lower income that are getting $3,000,000 who are matching 2 for 1 State and local money with the Federal.

Mr. WILSON. Then you say also in your statement:

> or we would have no serious objection to permitting States to approve applications for a Federal percentage of participation below the fixed Federal percentage established by law for that State.

That is coupled with the thought you first started your statement with that we must bear in mind that there is a great deal of hospital construction being done without Federal aid.

Let me ask you this: Do you think it ever would happen that there would be an application for less than one-third or less than 40 percent or less than 50 percent or less than two-thirds? Do you think that it would happen?

Mr. BUGBEE. I think in many States it would end up with every project getting the maximum. I think without any question, and I believe the Administrator of the act could give data on it, that certain States would undoubtedly build more hospitals with a permission for lower percentage grant and would exercise that.

Mr. WILSON. Am I wrong in my thinking that it is mandatory for the applicant now to take the third?

Mr. BUGBEE. Yes, though as I pointed out, if you are building two buildings and both of which were needed for a hospital, you could divide and simply apply for one of those two buildings and in that degree secure less than 33⅓ percent. I think that is not a unique experience.

Mr. WILSON. Thank you.

Mr. PRIEST. Any further questions?

Mr. Bugbee, we appreciate very much your statement.

Mr. BUGBEE. Thank you, sir.

Mr. PRIEST. The Chair understands, and if this is not correct, I will appreciate being corrected, that only one of the witnesses scheduled for today cannot be present for an afternoon session.

Apparently we are going to run too long to try to clear all of the witnesses before recess.

Mr. Priest. Mr. Hugh Murray, president of the National Association of Mutual Insurance Agents, we understand you have an appointment and cannot be here this afternoon. The committee would be glad to hear you at this time, and then we will recess until 2 o'clock if other witnesses present can be available at that time.

STATEMENT OF HUGH H. MURRAY, JR., PRESIDENT, NATIONAL ASSOCIATION OF MUTUAL INSURANCE AGENTS, RALEIGH, N. C.

Mr. Murray. Mr. Chairman and members of the committee, my name is Hugh H. Murray, Jr., of Raleigh, N. C. I am president of the National Association of Mutual Insurance Agents, composed of more than 3,200 mutual insurance agents operating as small independent businessmen in all parts of the United States.

At the outset I wish to state that the association I represent is categorically opposed to all of the proposed national health insurance programs, as such, when considered each in its entirety.

However, in practically all of the legislation on this subject now pending before your committee and the comparable committee in the Senate, there are contained certain provisions which we heartily endorse as being in the future interest and welfare of this Nation from the standpoint of health and longevity.

I refer to those provisions for aiding and fostering the education and development of a great number of physicians, dentists, and nurses, and for providing erection of vast numbers of hospitals and clinics throughout the country, both urgently needed.

We believe in "first things first." We do not want the cart before the horse.

It is an indisputable fact that there is a terrific shortage of doctors, dentists, and nurses in the United States.

No one denies that there is a vital need for more hospitals and clinics. Everyone agrees there is urgent need, now.

By the same token, gentlemen, there is agreement by all concerned, Democrats and Republicans alike, that no over-all health program can be passed at this session of Congress, and it is even doubtful about the next one.

Therefore, I desire to entreat you, on behalf of myself and the Association of Mutual Insurance Agents I represent, all outstanding businessmen in every section of the country, we appeal to you to separate these two vital necessities to our future health and welfare, from the very controversial issues about other phases, and pass them now, at this session, without any further delay.

Providing adequate personnel and hospital facilities will require at least 4 years. You can be deciding the health-program issue while these vital needs are being provided. If you passed 10 national health programs tomorrow, they couldn't be operated because we do not have the medical personnel or the hospitals.

In expressing opposition to the "complete" health programs as offered in pending legislation, I do not care to criticize them as socialized medicine nor as a trend toward communism, as has been done by so many witnesses heretofore.

We view these labels as a play upon ignorance, a generalized label which has no place in a hearing of this nature, of such vital importance to every man, woman, and child in the United States.

We believe that these health programs, whether mandatory or voluntary, cannot and will not lend themselves to workable administration without an expense totally unjustified from any standpoint. In other words, our association believes that the administrative costs of bringing a patient to the proper doctor's office, or to a clinic or hospital for treatment, would create a tax burden out of all proportion to the benefits which might be expected from these programs.

We have just grounds for these fears. We have a record of Government efforts for 15 years or more to control, direct, and allegedly promote and foster construction of residential housing in the United States. Actually, billions of dollars have been spent for administrative costs; huge technical and clerical staffs have been created and maintained at a taxpayer's expense, are still largely in existence today all over the country, and the results have been negligible.

We believe that adoption of any one of these over-all health-insurance programs would necessarily result in the creation of similar top-heavy bureaucracies, with big technical and clerical staffs, functioning more for political than health purposes in the final analysis.

Our association believes that there is a simpler and far more economical means of meeting and solving the question of national health. We believe that the following legislative actions will solve the basic problems involved:

(*a*) By aiding the education and development of a tremendous number of doctors, dentists, and nurses.

I am told by what I think is competent authority that the country gets approximately 12,000 new doctors a year; that over 15,000 students are applying for medical education, but that the schools and colleges can only accommodate 6,000 today, so that the situation is becoming worse.

Obviously, no health program can hope to accomplish anything without trained personnel to provide adequate medical attention. According to figures currently being quoted by Hon. Oscar R. Ewing, Federal Security Administrator, there is an appalling need for more doctors, dentists, and nurses in the United States. For example, he cites the fact that there is in Mississippi 1 doctor to every 1,500 of population, and 1 doctor to every 500 in New York.

In my opinion of health experts, even the New York ratio is too great for satisfactory protection of the Nation's health.

FSA Administrator Ewing goes even further, however, in pointing up the urgent need for more doctors. Speaking of the South, he cites the fact that throughout the entire South there is only 1 Negro doctor for every 4,900 patients, and in Mississippi the ratio drops to 1 in more than 18,000.

Obviously then, Mr. Chairman, the primary step must be to provide more doctors, dentists, and nurses. Our association believes that this step should be taken immediately, without attempting to connect it with any other phase of the health program. Even now, we feel, "it is later than you think." Doctors, dentists, and nurses, properly educated and trained, cannot be developed overnight.

The should be aided, subsidized, and encouraged in every possible manner. The professions should be glamorized and high lighted by especially focused programs to encourage youngsters to take up these professions. It is fundamental that no nation's health can improve or even survive without adequate medical personnel.

I believe this primary step needs no further elaboration on my part, except to point out that many additional medical schools must be created to meet this huge deficiency.

The next step in the program we favor, which I shall call Item (b), concerns the necessity for providing adequate hospital facilities and clinics at which, or through which, these additional doctors, dentists, and nurses may minister to the country's health needs.

The providing of adequate hospital facilities in every section of the country, and there is no section where sufficient facilities now exist, should definitely transcend all considerations of politics. Diseases, epidemics, illnesses know no racial, religious, or political subdivisions.

As in the case of our item (a), the hospital and clinic facilities cannot be developed overnight. Again, "it is later than you think."

This consideration should also be considered exclusive of any overall health program. The indisputable need already exists.

Our association beseeches this Congress to forget all thoughts of such terms as "Dixiecrats," or "Republicans" or "Democrats," and every other consideration of politics, and pass separate legislation at once to provide doctors, dentists, nurses, and hospital facilities.

Our third and last thought on the solution of this problem may be called item (e). Each one of the so-called national health programs refers specifically to, and expresses great concern for "the medically indigent."

We believe that the solution to providing adequate care for the medically indigent lies within the scope, easily adopted, of an amendment to existing social-security legislation.

There is no health crisis. Filling need for more doctors and hospitals would solve major health problems. Medically indigent will be a bugaboo, whether we have a national program or not. They will remain what the name implies—indigent.

As stated by Administrator Ewing in connection with the proposed administration plan, the machinery already exists for handling this problem without adding a top-heavy administrative organization on the taxpayer's shoulders.

Mr. Ewing has expressed greatest concern for those wage-earners between the rates of $20 and $80 per week. Our association can see no reason why adequate provisions cannot be made for medical allowances, on a sliding scale, perhaps, for this group, to be handled much in the manner that claims for unemployment, and for workmen's compensation benefits are now handled.

If the need is indicated, special consideration would be given to providing medical allowances for those whose income reach $5,000 per year, and to anyone who might demonstrate need for assistance.

We believe that with these provisions added to the social security laws, and all other Americans being permitted to seek and solve their medical problems as they see fit, there would arise little need for additional taxation, or, at the most, a matter of perhaps one-half of 1 percent increase in the present social security rate.

But, as matters now stand, no national health insurance program, whether mandatory, or voluntary, whether socialized or otherwise, not only cannot function, it cannot even be logically conceived or put on paper with any degree of intelligence, until—

(1) An adequate supply of trained medical personnel is available in every part of the United States, and

(2) Until adequate hospital and clinic facilities are made available where this trained medical personnel can function.

Therefore, at this time, in voicing its opposition to the entire group of so-called national health programs as such, the National Association of Mutual Insurance Agents respectfully implores the Congress to immediately divorce and pass separately such legislation as will act to provide adequate trained medical personnel of all types, and Nation-wide hospital and clinical facilities. When these vital needs are met, then will be time enough to consider national health programs.

Mr. Priest. Thank you very much, Mr. Murray.

Any questions, gentlemen?

We appreciate your appearance before the committee, sir.

At this point the committee is happy to have a statement from Hon. Burr P. Harrison, of Virginia.

STATEMENT OF HON. BURR P. HARRISON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Mr. Harrison. The subcommittee has before it for consideration several bills intended to extend and liberalize the hospital grant-in-aid authorized by the Hospital Survey and Construction Act (title VI of the Public Health Service Act).

It seems clear that approval of any one of these proposals would give rise to injustices and inequities if it did not provide for participation by those hospitals which availed themselves of the benefits of the original act prior to January 1, 1949.

While not proposing to argue the merits of any of the several basic bills before the subcommittee, I feel attention should be directed to the effect of the proposal dead line on a number of progressive and deserving medical institutions.

At present, the beneficiaries of the Hospital Survey and Construction Act can receive Federal grants-in-aid equal to one-third of the cost of planning, constructing, and equipping new hospitals and health centers. The pending proposals would change this proportion to equal the State's allotment percentage under the act, in most cases more than one-third.

With such a change applicable only to projects approved on or after January 1, 1949, the alert, prompt-acting institutions which obtained early approval of their expansion plans would find their allotments pegged at the existing one-third rate. It appears 198 projects, of which only 10 were completed by the first of this year, would be affected by this cut-off date.

Even projects which received preliminary, but not final, approval prior to January 1, might be placed in the same status, depending on the view of the general counsel of the United States Public Health Service.

The 198 projects most definitely concerned are located in 42 States. More than 80 percent of them did not receive their final approval until the second half of 1948.

In most cases, the two-thirds of the cost subscribed by the applicant institution was raised through debt financing, bond issue, revenue certificate, or other pledge of indebtedness. The institutions, in general have shot their bolt. They have little hope of substantial additional revenue for capital improvements from local sources for many years to come.

In this connection, it is important to realize that these benefitting institutions are not all set in the matter of facilities as a result of the combination of local and Federal financing arrived at under the present law. The extent of the facilities built or building had to be based on available funds and not on the real needs of the communities concerned.

In fact, the additional beds provided by these new facilities will permit the institutions to achieve, in general, merely one-fourth of the minimum bed requirements established by State plans. And these early projects are located, for the most part, in "A" and high "B" priority areas.

Now that they have strained their financing capacities to the utmost, these institutions seem destined to be frozen in their existing facilities, or those still inadequate ones now under construction. Few can hope to raise additional money locally to qualify for further grants, even under the proposed liberalized Federal-aid percentages.

One example might be of use to the committee in its consideration of the propositions under study. I should like, therefore, to offer a brief account of the experience of King's Daughters Hospital, Staunton, Va.

It is located in a city of 17,000 population and serves an area of 69,000 residents. It is in the center of an intermediate hospital district, as established in an approved State plan, as required by the existing law. The hospital, owned and operated by a nonprofit corporation, maintains 75 beds in a building 45 years old. The physicians who practice there have declared it woefully inadequate and a serious handicap in the effort to provide medical care by modern standards.

Realizing this, the citizens of the district undertook a fund-raising campaign in the spring of 1947. The pledges obtained in that drive totaled $975,000. They were to be payable over a 3-year period.

On December 3, 1948, bids were opened for construction of a new 117-bed hospital on a new site. Every effort to economize was made in the planning of this building. No ornamentation was contemplated. Functional design was the watchword. Despite this policy, the low bid was $2,045,300, whereas the allotment was $1,644,000. To this, the costs of equipment, site acquisition, architect's fees, and supervision of construction had to be added, a total of approximately $400,000.

The board of trustees of the hospital reexamined its estimates. By reducing the equipment allowance from $165,000 to $100,000 and effecting other economies, all of them considered drastic, and by arranging to borrow approximately $175,000, the board was able to commit itself to a construction contract on December 10, 1948.

In retrospect, it has become apparent that the contract was entered into at or near the peak of construction costs. The board had no choice, however, inasmuch as the State had required it to meet a December 30 dead line.

Almost $233,000 in pledges remains outstanding, and payments on pledges have tapered off sharply since January 1949; many contributors have found it difficult to meet their commitments, although their intentions still are to pay on their pledges as soon as their individual financial situations permit.

The obligations of the hospital, however, are increasing steadily as construction progresses. Unless the subscribers pay off their pledges at an increased rate in the next few months, the board will have to take steps early in the fall to obtain a short-term loan of several hundred thousand dollars.

Part of this short-term obligation would be liquidated with the payment of Federal and State allotments, but perhaps $200,000 would have to be refinanced on a long-term basis. The superimposition of such amortization and interest charges on the existing debt of the institution would produce a debt burden which would stifle further expansion attempts, needed if the hospital is to serve its community adequately.

This situation is not isolated. There probably exist, in fact, hospitals even more sorely pressed financially; if the January 1, 1949, deadline is retained in any legislation designed to liberalize the Federal grant-in-aid policy, the institutions which have exercised the most initiatve will be penalized. They will get only the one-third Federal contribution heretofore authorized. The hospitals which have delayed pressing their applications will benefit by receipt of larger grants in most cases.

I hope, therefore, that in whatever legislation the subcommittee sees fit to recommend it will take into consideration the principle sought to be served by H. R. 3737. This bill would make the proposed new grant-in-aid formula retroactive to August 13, 1946, the date on which the present act became law.

This measure, in other words, would place all beneficiaries under the act on the same basis. Newly approved applicants would receive grants in accordance with the new schedule. The institutions already engaged in construction on the old basis and those having completed their authorized expension would receive additional money in accordance with the State allotment percentage, instead of the one-third which present law provides.

The latter hospitals, therefore, would be able more nearly to approach the medical care requirements of their communities.

In the interest of equitable treatment, I commend H. R. 3737 to the consideration of the subcommittee with the suggestion that there is merit in altering the arbitrary January 1, 1949, cut-off date contemplated by the other proposals under study.

Mr. Priest. The Chair has a statement from Lloyd C. Halvorson, an economist of the National Grange, which will be inserted in the record at this point.

(The statement is as follows:)

Statement of Lloyd C. Halvorson, Economist, the National Grange

The National Grange has supported the Federal hospital survey and construction program from the beginning when it was first known as S. 191, the Hill-Burton bill. The reasons for which we supported the bill then apply with equal force today. Much needs still be done to improve the health facilities of the Nation, and especially the facilities in rural areas.

The facilities in rural areas have not only failed in many instances to keep up with advances in medical science but are also inadequate from the standpoint of number of beds and accessibility.

Good health is a matter of national concern. Physical fitness and endurance of the people is as important to national defense as airplanes and munitions. Also, we know that a person with impaired health can move about and thus become a public charge in a different State from the one in which his health was neglected.

Hospital facilities in many rural areas are either lacking entirely or are very inadequate. Farm people know this from experience and statistics bear it out. A United States Department of Agriculture publication entitled "Better Health for Rural America" (1945) stated:

"Widespread rural areas are very poorly served by hospital facilities. Over 1,250 of the 3,070 counties of the Nation are without a single satisfactory general hospital. Over 700 of these counties have populations exceeding 10,000 people.

"To serve people properly, there ought to be about 4.5 general hospital beds for every 1,000 persons in the State. Quite a few cases of illness among rural people, however, are and should be referred to city hospitals for care. While in the cities, therefore, 5 or more beds per 1,000 persons may be necessary, in the rural areas 3.5 or 4 general beds per 1,000 are probably adequate. The fact is that today most rural areas do not have even 2.5 beds per 1,000."

The State of New York is not by any means the most lacking of the various States in rural hospital facilities. However, we happen to have a copy of a letter dated August 21, 1947, which John J. Bourke, executive director of the New York hospital survey, sent to Henry D. Sherwood, master of the New York Grange. The following excerpt explains in part the hospital situation in that State.

"As I mentioned above, our regional councils have appraised all of the 582 hospitals in the State from the standpoint of suitability, safety, and adequacy. In carrying out this type of work, one is conscious of the present deficiencies in rural hospital care. For example, there are a number of rural counties that have no adequate hospital facilities. In the main, rural hospitals have been established as private profit-making enterprises by an individual or group and, in some instances, by physicians in order to have the tools with which to work. For the most part, these hospitals are in converted frame dwellings which present definite fire hazards. They do not have the equipment, physical plant arrangement, or balanced medical staff which are indicated in modern medical practice, and in the main they operate as isolated institutions with very little working relationship with larger modern and adequately staffed urban hospitals. When one analyzes the flow of patients under such situations, we find that a large proportion of those needing hospital care, who have the liberal funds to go to the larger urban hospitals, do so. In one rural county 50 percent of all the persons requiring hospital care during 1945 left the county, traveling from 35 to 60 or more miles to secure their hospital services. This county has 6 converted frame dwellings serving as hospitals with capacities from 8 to 32 beds. Under this type of situation, it is difficult to support local medical service, and I believe that the provision of a fewer number of modern, larger facilities would result in more physicians practicing in the area, and the people best able to support the services would do so. As a minimum estimate, up-State New York will require about $80,000,000 of new modern hospital construction. Under the Federal Hospital Survey and Construction Act, New York State will receive less than $15,000,000 in Federal grants over the next 5 years. In other words, only $45,000,000 of hospital construction of all types can be aided under this program. The financial condition of hospitals at the present time is not good, and I believe every effort should be made to encourage Congress to liberalize the appropriations for this well-accepted and necessary program. One of the most difficult tasks for the Commission and its State advisory council will be the allocation of the limited Federal funds since the number of applicants will greatly exceed the number that can be aided. I am forwarding a copy of the recommendations for chronic disease hospital care, and any support that the Grange can give to this program should be very worth while."

We feel it is very appropriate for the Hospital Survey and Construction Act to specify that grants-in-aid be allocated on the basis of need with added priority to rural areas.

Ideally, every local community and every State should provide itself with adequate hospital facilities, but we know that for some reason this has not been done. A major reason for this is that some local communities and States lack the necessary resources. There is a tremendous variation in the per capita income and taxable resources among the States and within the States.

We feel that Federal aid to hospital construction is an excellent way for the Federal Government to improve health conditions. It does not invoke any great danger to our American way of life. In other words, it avoids such problems as means tests, and there is little said of the danger of Federal or political control over economic activity or political thinking and behavior.

Grange members all over the Nation have participated in the Federal hospital program at all levels of activity. So far as I can tell, our members have looked upon the program as not only desirable but nearly as indispensable if they are ever to get adequate hospital facilities. This, I believe, is reflected in the following resolution which was adopted by the delegate body of the National Grange last November:

"The program under the Hospital Survey and Construction Act should be continued and extended under a policy of flexibility permitting adaptation as may be required to meet changing needs. The present authorization of $75,000,000 per year should be increased in view of the urgent needs for the establishment of additional hospital beds and clinics and health centers in many areas of the country."

In addition to this resolution, a number of other resolutions were adopted that relate to some degree to this bill. They are as follows:

"1. The program under Public Law 725 and the hospital program of the Veterans' Administration should be closely integrated in the interest of good planning.—Adopted.

"2. Hospitals within service areas should be functionally or organically associated with one another so that the patient may benefit from the resources of all.

"3. Governmental agencies having assumed responsibility for hospital care for patients and non-governmental agencies purchasing hospital care should pay the established rate for such care.—Adopted.

"4. Hospitals, health departments ,and all other health agencies should seek every method for coordinating their efforts and integrating their functions in the interests of greater efficiency and service to the patient.—Adopted.

"5. Diagnostic clinics, outpatient services, and home medical care and allied programs should be developed more extensively in extending health services for all.—Adopted.

6. Hospitals should intensify and extend their basic activities in research and education.—Adopted.

"7. Preventive medical and dental service, and public health education should be carried out more widely as regular functions of the modern hospital.—Adopted.

"8. Insofar as possible, the general hospital should provide facilities for the care of all types of illness, with increased attention to the diagnosis and treatment of the patient with long-term illness.—Adopted.

"9. The pressing need for additional facilities for the care of the mentally ill and chronic diseases in general hospitals makes it necessary that special emphasis be given to this problem in the original State hospital plans and any revision of these plans under Public Law 725. A careful study to develop recommended standards is needed in this area for the guidance of State organizations under this act.,—Adopted.

"10. To develop and adequately meet good standards of patient care, it is recommended that all hospitals, nursing homes, and other facilities for the care of the sick should meet at least minimum standards through the mechanism of licensure.—Adopted.

"11. The control of local facilities should be by the people in that locality on a cooperative or community basis, where possible with an elected board of directors, representative of lay and professional groups.—Adopted.

"12. Lay and professional organizations and governmental agencies should join in conducting a health education program and in developing plans for adequate facilities and health services which will include well coordinated and highly integrated networks of mobile units, clinics, community hospitals, district hospitals, regional hospitals, and great medical centers.—Adopted.

"13. That each State agency operating under the Hospital Survey and Construction Act consider carefully the advisability of organizing a rural hospital subcommittee having representation from the major general farm organizations within the State and from the State land-grant college, to advise the State concerning matters of importance in rural areas."

Our health program covers a number of additional points which I will not take the time or space to cover here. I should mention, however, that we are very much behind group hospitalization plans and health cooperatives. They are quite an essential complement, we feel, to the hospital construction program.

In the previous year, the delegate body adopted a resolution instructing the National Grange to support appropriations for the hospital program in line with the authorization.

We believe that it is desirable to vary the Federal share of the construction cost from State to State as some States are less able to pay for hospitals than others. Also, it seems desirable to us to give the States authority within a maximum and minimum to vary the Federal share as provided in title III of S. 1679. We feel it is important that the Federal share not be so high as to stop supplementary State aid programs.

From what we understand about "coordinated use of hospital facilities" it means that all the medical equipment and skill in the whole hospital area will stand ready to render the best possible aid to a patient. In other words, not only the limited facilities of the local hospital will be readily available in case of need, but rather all the facilities and skill in the hospital area. In addition, we understand that under a coordinated hospital program it may be possible to bring more interns and doctors of different skills into rural areas. Because of this we favor section 5 of S. 614 which provides for studies and demonstrations in coordinated use of hospital facilities.

We note that section 309 (a) of title III, S. 1679, broadens the definition of a health center to include facilities for group practice of medicine and dentistry (or both) by or for a cooperative or other nonprofit cooperation. Many rural communities that cannot justify a hospital need some sort of health facilities. In some areas our members have been active in forming cooperative health clinics to meet their local needs. We feel it is quite appropriate that they get some Federal assistance even if they are not in a position to build something as large as a hospital.

Mr. PRIEST. We also have a statement from Dr. John A. Ferrell, executive secretary of the North Carolina Medical Care Commission which will be inserted in the record at this point.

(The statement is as follows:)

STATEMENT BY JOHN A. FERRELL, M. D., EXECUTIVE SECRETARY, NORTH CAROLINA MEDICAL CARE COMMISSION

INTRODUCTION

The North Carolina Medical Care Commission appreciates the invitation to testify before your committee on pending legislation for the continuation and enlargement of the hospital construction program. The Hospital Construction Act 725 has been of enormous value in the development and expansion of a State-wide integrated hospital program in North Carolina. The 2 years of work accomplished merely represents a beginning of the task. The work should continue for several years and the program should be expanded at the Federal, State, and local levels.

From the standpoint of North Carolina, it is urged that flexibility be provided in the Federal laws under consideration in such way that the Federal aid for approved projects will not fall below a minimum of, say 33⅓ percent or exceed a maximum to be determined, possibly the State's percentage allotment. Each State agency should be allowed discretion within a prescribed range to allocate the Federal aid in the manner that will most effectively insure progress in hospital construction.

Federal funds should be made available to share with State funds in meeting the cost of administering the program at the State level. An allocation for this purpose of not less than 1 percent of the amount of the yearly Federal allocation to the State or more than 2 percent would be satisfactory for North Carolina.

WORK IN NORTH CAROLINA UNDER THE UNITED STATES HOSPITAL CONSTRUCTION ACT 725 IS WELL ADVANCED

1. When the Federal hospital construction appropriation was made available in August 1947, North Carolina had established the North Carolina Medical Care Commission as the State's sole hospital agency; had adopted all State and local legislation essential for carrying out the program; and had engaged full-time professionally trained personnel to administer the program. The State appropriations shown in attached exhibit A (job No. 582) have been made for hospital construction by the legislatures of 1947 and 1949. It will be noted that the medical care commission has been provided with State funds for the two biennial periods to end June 30, 1949, and June 30, 1951, that total $13,076,927, to be used with Federal and local funds in sharing the cost of building and expanding local hospitals and health centers.

2. It will be noted also that for the same period of 4 years, the State has appropriated for building and expanding State-owned hospitals, for teaching purposes and for the care of mental, tuberculosis, spastic, and orthopedic patients, $32,744,251. Of this amount nearly $4,300,000 was specifically appropriated to relieve the commission of using Federal funds in the future toward the cost of construction of State-owned hospitals and in order to permit all Federal funds combined with State and local funds to be employed in building and enlarging local general hospitals and health centers throughout the State. Exhibit B is a general summary of the hospital resources of North Carolina as of January 1, 1947 (job No. 342–A).

3. The attached map, exhibit C (dated June 17, 1949) is a reflection of the North Carolina State hospital plan. It shows by counties the present hospitals, indicates their size in beds, the priority rating of each county, and in color 35 counties in which new local general hospitals have been approved, 17 of which are already under construciton. Exhibit D is a graphic cost analysis of the 17 hospitals now under construction. Exhibit E (job Nos. 585 and 595) is a cost tabulation of the 28 approved local general hospitals for the 2 years ending June 30, 1949.

4. In addition to providing aid for the local general hospitals, the commission has allocated Federal funds toward State-owned hospital projects that involve approximately $750,000 of Federal funds and at a total expenditure in excess of $2,500,000.

5. The commission has a staff consisting of its executive secretary, an accounting and clerical staff, and a technical staff composed of an architect, construction engineer, mechanical engineer, and three hospital administrators.

6. The map, exhibit C, shows that the 28 local general hospitals approved are all located in high-priority areas which are chiefly rural and agricultural. Thus little or no assistance has been given to the expansion of hospitals in about 70 counties of the State in which many of the present hospitals are located. The counties in which the large medical centers are located are central and populous. They have been asking for aid for more than 2 years. Some of them already have in hand the local share of the funds for substantial construction projects which will be relatively large, consisting in many instances of from 100 to 300 beds. As each 100 beds on the prevailing cost basis of using 33⅓ percent of Federal funds will require the encumbrance of $400,000 of Federal funds, it is obvious very few such projects can be supported from the slightly more than $3,000,000 of Federal funds available to the State yearly. If the amount of Federal funds for the State should be increased and there should be a mandatory corresponding increase in the percentage of Federal funds allocated for each project, there would be no flexibility and the State would be unable to increase the number of projects or the number of beds.

However, on the flexible basis urged, the State could finance more beds and expedite the development of an adequate State-wide system of hospitals. No difficulty in the present plan of allocating State and Federal aid to the counties has been encountered. The sliding-scale basis is set forth in the attached exhibit F (job No. 245, method VI). Notwithstanding the present Federal aid is rigidly one-third the State of North Carolina contributes an average of one-third, but on a sliding scale that allows only 10 percent of State aid to the wealthiest counties, and 50 percent of State aid to the poorest counties, and for other counties a range is between these extremes. Thus the Federal plus State participation enables some of the poorest counties to obtain hospitals by contributing only one-sixth of the total cost; whereas some of the wealthiest counties contribute 57 percent. Several of the poorest counties are so nearly bankrupt that they find it difficult even on this liberal basis to take advantage of the construction aid available, and their problem of operating the hospital is even greater. The plea of North Carolina, then, is that the Federal appropriation be doubled, as contemplated by Senate bill 614 and House bill 2176, but that the allocations to the States be on a flexible basis and not on a rigid fixed formula. The urgent need in North Carolina, that has State aid available, is to hasten aid all along the priority scale by approving more projects and by obtaining more hospital beds. In order to accomplish this it is proposed to continue requiring a substantial amount of State and local funds for approvable projects and to spread more widely over the State the increased Federal funds. We can use the additional Federal funds promptly, and not depart very far from the basis prescribed by our method VI.

COST OF ADMINISTRATION AT STATE LEVEL

In North Carolina the commission's hospital construction program slightly exceeds a total of $10,300,000 a year. The second year's program was inaugurated before any of the first year's projects were completed; and the third year's program will be underway before many of the first year's projects will be completed. That is to say that by the third or fourth year 40 to 50 hospitals will be under construction, and the volume of work will involve $30,000,000 to $40,000,000.

As a basis for payments of State and Federal funds for construction, the State's personnel must make frequent inspections of the construction work relative to the materials used, the workmanship, and the amount of progress. The services of architects, engineers, and hospital administrators will be required for the task.

The Medical Care Commission recently was made responsible for the licensing of the 175 or more hospitals in the State. The licensing in each case will involve an appraisal of each hospital relative to its scientific, business, and administrative procedures. Competent personnel trained in hospital administration will be necessary for this task. All sites for new hospital projects must be inspected with respect to location, elevation, soil composition, drainage, water and sewerage facilities, roadways, etc.

The 1949 general assembly gave the commission an appropriation of $107,000 annually for the next 2 years for general administrative expenses. Approximately $12,000 of this amount will be required to cover salary increases authorized by the legislature. The commission needs an additional $50,000 to $100,000 annually for administrative expenses. States having little or no State appropriation for general administration expenses may need more. Flexibility in determining the amount of Federal aid toward the cost of administration will be needed, and of course each State agency should, in submitting a State plan, describe its needs.

In conclusion, North Carolina needs and can use effectively all increased Federal aid contemplated by House bill 2176 and its companion, Senate bill 614. It needs some financial assistance toward the cost of general administration. It urges a flexible basis for utilizing Federal allocations for hospital construction to the State, so that the maximum expansion of its hospital facilities can be accomplished through the effective employment of Federal aid, along with State and local funds.

(Balance of exhibits filed with committee.)

EXHIBIT A.—*Appropriations by 1947 and 1949 legislatures*

I. TO NORTH CAROLINA MEDICAL CARE COMMISSION

	Biennium July 1, 1947–June 30, 1949	Biennium July 1, 1949–June 30, 1951
Operating expenses:		
I. General administration	$123, 040	$214, 576
Student loan fund—$50,000 appropriation by 1945 legislature [1]	[1] 50, 000	[1] 30, 000
Hospital care of indigents—$1 per day for each indigent	700, 000	700, 000
II. Permanent improvements—local hospitals and health centers	6, 250, 000	6, 826, 972

[1] The student loan fund (1945) was originally $50,000. Up to May 1, 1949, approximately $20,000 had been encumbered, leaving $30,000 for loans to June 30, 1951.

II. TO STATE-OWNED HOSPITALS FOR PERMANENT IMPROVEMENTS

	Number of hospitals	Amounts appropriated by 1947 legislature	Additional appropriations by 1949 legislature	Amounts increased by 1949 legislature to—
Mental hospitals, including Butner	4	$7,917,036	$7,201,806	$15,118,842
Tuberculosis hospitals	3	1,942,920	5,556,889	7,499,809
Orthopedic hospitals	1	53,500	70,100	123,600
Cerebral palsy hospital	1	450,000		450,000
University teaching hospital and homes for nurses and interns for 4-year medical school	1	5,290,000	3,262,000	8,552,000
Dental school, building and equipment	1		1,000,000	1,000,000
Total		15,599,956	17,144,295	[3] 32,744,251
Deduction of amount of Federal funds anticipated		4,246,938	[2] 4,246,938	
Net State appropriation		11,353,018	21,391,233	32,744,251

[2] To assume by State, items charged to Federal funds in 1947.

[3] Amount of Federal funds devoted to State-owned hospitals, $533,645.41.

EXHIBIT B.—*A complete list of North Carolina hospitals showing beds for whites and Negroes, Dec. 8, 1947—Summary*

I. HOSPITALS AND BEDS BY MEDICAL TYPE

Type	Hospitals				Grand total	Beds				Negro only
	Grand total	White only	White and Negro	Negro only		White only	White and Negro			
							Total	White	Negro	
General	129	54	65	10	9,068	3,494	4,965	4,029	936	609
Allied:										
Children's diseases	3	3	0	0	131	131	0	0	0	0
Eye, ear, nose, throat	6	5	0	1	103	81	0	0	0	22
Maternity	7	7	0	0	77	77	0	0	0	0
Orthopedic	1	1	0	0	28	28	0	0	0	0
Venereal diseases	2	0	2	0	420	0	420	110	310	0
Tuberculosis	23	7	16	0	2,004	446	1,558	863	695	0
Mental and neuropsychiatric	8	7	1	0	6,743	4,422	37	19	18	2,284
Chronic	1	0	1	0	160	0	160	110	50	0
Total	180	84	85	11	18,734	8,679	7,140	5,131	2,009	2,915

II. HOSPITALS AND BEDS BY OWNERSHIP

Ownership	Hospitals				Grand total	Beds				Negro only
	Grand total	White only	White and Negro	Negro only		White only	White and Negro			
							Total	White	Negro	
Church	12	7	2	3	1,317	995	125	116	9	197
City	3	1	2	0	523	61	462	248	214	0
City-county	4	1	2	1	284	16	143	110	33	125
Corporation	6	4	2	0	257	171	86	80	6	0
County	25	2	22	1	1,323	50	1,254	802	452	19
Individual	31	26	3	2	613	471	110	94	16	32
Industrial	1	0	1	0	50	0	50	35	15	0
Nonprofit association	83	33	46	4	6,090	2,291	3,541	2,972	569	258
Partnership	6	6	0	0	168	168	0	0	0	0
State	9	3	5	1	8,109	4,456	1,369	674	695	2,284
Total	180	82	86	12	18,734	8,679	7,140	5,131	2,009	2,915

NOTE.—Number of beds reported for hospitals reflects capacity by design and does not include bassinets. Data are taken largely from hospital survey of 1946.

Mr. Priest. The Chair has a statement from Mr. Jack R. Nuzum, executive secretary of the Taylor County Board of Trade, member of the West Virginia House of Delegates. The statement will be incorporated in the record at this point.

(The statement is as follows:)

Statement of Jack R. Nuzum, Executive Secretary of the Taylor County Board of Trade and Member of the West Virginia House of Delegates

Permit me to introduce myself. I am Jack R. Nuzum, executive secretary of the Taylor County Board of Trade, member of the West Virginia House of Delegates, and I am here to speak for passage of H. R. 4215 and to plead the case of a community of 8,200 which is in danger of losing its hospital facilities.

STATEMENT OF EFFORTS MADE BY THE CITY OF GRAFTON TO SECURE A MUNICIPAL HOSPITAL

The attempt by the city of Grafton to raise sufficient money in order to construct a municipal hospital might be divided, or recorded into three phases:

(1) In the early 1930's, the voters of Taylor County authorized a county-wide special levy for the purpose of constructing a hospital in the city of Grafton. A test case was instituted concerning the legality of the levy issue and the Supreme Court of West Virginia voided the action of the voters on some technicality in the election call.

(2) In August 1932 the voters of the city of Grafton authorized a special levy which would raise $40,000 for the purpose of starting hospital construction; $31,000 was added to the amount from current revenues by the city of Grafton, and with a $64,000 grant from the Works Progress Administration, construction was started about the 1st of January 1939. The construction was under the direction of Don J. Byrum, Inc., of Wheeling, W. Va., as contractor, and L. D. Schmidt, of Fairmont, W. Va., as architect. Work ceased early in 1940, after some $135,000 had been expended.

(3) On May 27, 1942, the Reconstruction Finance Corporation approved an application from the city of Grafton for a loan of $160,000 to be based upon revenue bonds to be paid by earnings from the hospital, providing the citizens of Grafton would approve a 3-year levy which would provide an additional $40,000. This bonding levy was approved on July 28, 1942, and soon after that date the construction work was resumed.

After the hospital had been completed, it was found that there was not sufficient money to equip it completely. A drive was staged in the city of Grafton for donations, under the direction of a committee appointed by the Grafton Women's Club, and approximately $20,000 was raised from the citizens for the purpose of buying the necessary equipment in order that the institution might be occupied. The equipment was secured and the institution was opened on March 7, 1945.

For further information, I am submitting a copy of the financial statement of the Grafton City Hospital for the period ending as of December 31, 1948. I am also submitting a copy of the comparative operating statement for the years 1946, 1947, and 1948.

Grafton City Hospital financial statement as of Dec. 21, 1948

Assets:		
Current assets:		
Petty cash fund		$300.00
Cash in bank		—448.02
Cash (pay-roll account)		------
Cash (withholding tax deposits)		------
Deposit State Sinking Fund Commission		100.00
Cash grading and landscaping fund		14.94
Accounts receivable:		
In-patients	$41,742.25	
Out-patients	3,559.15	
Total	45,301.40	

Grafton City Hospital financial statement as of Dec. 21, 1948—Continued

Assets—Continued		
Current assets—Continued		
Less reserve for loss	$5,438.73	
		$39,862.67
Supplies and materials inventory		21,320.99
Prepaid insurance		524.04
Total assets		429,155.86
Fixed assets:		
Land and improvements		10,736.28
Building		296,360.35
Permanent fixtures		312.29
Equipment		9,386.13
Equipment (from old hospital)		14,878.90
Furniture and equipment (new)		35,807.29
Total fixed assets		367,481.24
Totals assets		429,155.86
Liabilities:		
Accounts payable (current)		14,131.58
Unidentified receipts		124.85
Bond interest accrued		8,320.00
4-percent revenue bonds		156,000.00
Capital investment (city of Grafton)		204,747.43
Capital (donated by others)		14,693.87
Surplus, January 1, 1948	$37,861.62	
Plus net profit 12 No. 1948	—6,723.49	
		31,138.13
Total liabilities, capital and surplus		429,155.86

Grafton City Hospital, comparative operative statements, years 1946, 1947, and 1948

Income items	12 months 1946	12 months 1947	12 months 1948
Income items:			
Private rooms	$23,230.00	$27,514.00	$29,736.00
Semiprivate rooms	17,855.00	20,197.45	21,518.00
Wards	18,894.50	26,150.00	33,129.00
Flat rate debit variances	51.65	-----	-----
Operating room:			
In-patients	14,105.50	22,373.20	24,364.25
Out-patients	237.50	403.00	650.00
Delivery room	2,445.00	3,594.00	3,813.50
Nursery	2,151.00	2,171.00	3,772.00
X-ray service:			
In-patients	3,831.50	5,894.50	6,281.50
Out-patients	3,807.75	5,022.50	4,769.75
Laboratories	9,442.70	10,869.75	13,920.50
Do	1,264.00	1,672.00	1,516.00
Drugs, dressings:			
In-patients	16,349.88	27,566.95	35.283.72
Out-patients	2,721.52	2,537.38	3,114.20
Dietary:			
Meals charged in-patient	586.75	987.53	1.066.25
Meals for cash	97.31	516.07	497.23
Income: Telephone and telegraph	111.99	34.55	-----
Cash discounts earned	28.45	-----	-----
Income:			
Confectionery depreciation	-----	9.77	272.79
Others	26.51	-----	234.18
Memorial fund	961.82	-----	-----
Total gross profit	118,200.00	157,513.65	183.918.87

Grafton City Hospital, comparative operative statements, years 1946, 1947, and 1948—Continued

Income items	12 months 1946	12 months 1947	12 months 1948
Less expenses:			
Administration:			
Salaries and wages	$6, 525. 79	$8, 743. 49	$14, 183. 00
Stationery and office supplies	1, 119. 92	1, 810. 88	2, 310. 52
Miscellaneous	112. 92	273. 68	634. 76
Telephone and telegraph	919. 98	908. 40	1, 164. 12
Accounting and legal fees	1, 414. 58	325. 00	1, 180. 87
Insurance	958. 62	974. 50	1, 463. 14
Collection expense	54. 07	947. 47	1, 240. 22
Group insurance	------------	323. 40	528. 08
Dietary:			
Salaries and wages	6, 386. 89	8, 829. 84	9, 607. 59
Miscellaneous supplies	374. 91	830. 92	545. 58
Food	15, 292. 43	19, 603. 67	21, 620. 66
Laundry:			
Miscellaneous supplies	------------	61. 64	------------
Service	3, 325. 21	4, 892. 04	5, 490. 05
Housekeeping:			
Salaries and wages	3, 198. 07	3, 942. 66	5, 903. 20
Miscellaneous supplies	419. 33	1, 095. 24	1, 313. 24
Plant operation:			
Salaries and wages	2, 767. 07	3, 516. 10	5, 611. 38
Miscellaneous supplies	4, 079. 74	5, 513. 96	6, 436. 38
Maintenance and repairs:			
Salaries and wages	------------	------------	------------
Miscellaneous supplies	1, 151. 71	1, 397. 36	3, 777. 81
Medical and surgical miscellaneous supplies	11, 779. 47	27, 426. 33	24, 192. 61
Nursing services:			
Salaries and wages	28, 493. 54	38, 858. 70	50. 324. 06
Miscellaneous supplies	1, 326. 41	1, 195. 79	1, 217. 83
X-ray department:			
Salaries and wages	------------	------------	------------
Miscellaneous supplies	984. 39	1, 378. 68	1, 708. 38
Laboratory:			
Salaries and wages	2, 123. 66	3, 288. 61	4, 809. 36
Miscellaneous supplies	83. 47	21. 70	797. 19
Operating room:			
Salary	------------	------------	------------
Miscellaneous supplies	17. 87	------------	------------
Pharmacy: Miscellaneous supplies	------------	------------	5. 00
Interest on bonds	6, 400. 18	6, 206. 50	6, 240. 00
Loss on bad accounts	------------	------------	18, 209. 33
Courtesy allowances	3. 25	112. 38	------------
Flat rate credit variances	769. 66	------------	------------
Total operating expenses	100, 383. 13	142, 481. 14	190, 642. 36
Net operating profit	17, 817. 20	15, 032. 51	−6, 723. 49

An examination of this comparative statement for the 3 years mentioned will show a steady increase in expenses, starting with $100,000 in 1946 and ending with $190,000 in 1948. It is true that the revenue increased greatly during this period, but not in sufficient amount to take care of the increase in operating expenses.

In the operating expenses an expenditure for interest on bonds is shown. For the purpose of bookkeeping, this is carried as expense. As a matter of fact, the interest on the bonds was not paid and this is an additional obligation.

In addition to the unpaid interest, the hospital is in default on bond payments in an amount in excess of $20,000.

An examination of the financial statement for the period ending December 31, 1948, will show accounts receivable in the amount of $39,826.67. These accounts are being aged and analyzed and it is the impression of the Board, from past experience, that more than one-half of this account will be be uncollectible and will have to be written off as "bad accounts."

Grafton is the county seat of Taylor County. The county has a population of approximately 18,000. All the surrounding counties, with the exception of Preston, have available hospital facilities, and therefore the patients for the Grafton City Hospital are drawn almost entirely from the residents of the county. The hospital actually operates at about 60 percent of its capacity on a year-round basis.

GRAFTON CITY HOSPITAL BOARD OF DIRECTORS.
By R. VIRGIL ROHRBOUGH, *Secretary*.

Under the Hill-Burton Act, Grafton City Hospital does not qualify for Federal-aid funds, only new construction is embraced by this act. Our community took the initiative while others waited for legislation such as the Hill-Burton Act. Under H. R. 4215 funds are provided for maintenance and operation; this would ease our critical situation. We have changed our hospital director three times and have made every effort to make our hospital meet its obligations but as indicated in the financial statement, we are unable to make our interest payments on our bonds, or principal payments on the bonds held by the Reconstruction Finance Corporation. If Federal funds were awarded our hospital and we were able to make our bond payments, we could keep our hospital facilities but if we continue to backslide further in debt, we are in danger of losing it.

Mr. PRIEST. The committee will stand adjourned until 2 o'clock this afternoon.

(Thereupon, at 12:45 p. m., the committee recessed to reconvene at 2 p. m. of the same day.)

AFTERNOON SESSION

The subcommittee reconvened at 2 p. m., upon the expiration of the noon recess.

Mr. PRIEST. The committee will come to order.

The Reverend John G. Martin, a past president of the American Protestant Hospital Association, and the administrator of the Hospital of St. Barnabas, of Newark, N. J., desires to present for the record a statement. He was present during the committee hearings this morning, and had to leave. His statement will be included at this point in the record.

(The statement referred to is as follows:)

TESTIMONY OF REV. JOHN G. MARTIN, S. T. D.

Honorable chairman and members of the committee, for the record, my name is John G. Martin, a clergyman of the Episcopal Church. I am a past president of the American Protestant Hospital Association which I have the honor to represent at this hearing. I am also a past president of the New Jersey Hospital Association and now a member of its board of trustees, a member of the board of trustees of the Hospital Service Plan of New Jersey, and a member of the board of trustees of the Hospital Council of New Jersey.

I am the administrator of the Hospital of Saint Barnabas and for Women and Children, of Newark, N. J., serving my 26th year in that capacity.

My appearance here as the representative of the American Protestant Hospital Association is at the request of its president, Dr. Chester C. Marshall, administrator of the Methodist Hospital, of Brooklyn, N. Y.

Members of the Protestant Hospital Association are greatly interested in the Hospital Survey and Construction Act and find its provisions advantageous to their activities of serving the health needs of their several communities. Many of the hospitals of our association are of long standing and belong to a period of hospital construction practices that are not adequate to the requirements of the present day. It is, therefore, understandable that building projects are demanding urgent attention at this time.

One of the helpful features of the act is its provision for the improvement and enlargement of existing facilities. Recent disastrous experiences in individual hospital buildings, such as the menace of fire and other hazards, lead us to the conclusion that the program of replacement of unacceptable beds is of major importance. We are in possession of the information and scientific data necessary to the planning of buildings of maximum safety. This knowledge should be implemented in works of improvement.

In undertaking responsibility for the care of sick and disabled members of our populace we cannot avoid the necessity of providing every safeguard for the lives of our patients.

One of the greatest deterrents to the work of improvement or replacement of old buildings is the financial difficulty involved. The constantly diminishing returns from philanthropic sources for these projects make it imperative for governmental divisions of our society to undertake an increasing amount of responsibility for financing this work. It is, therefore, encouraging to look forward to a greater support by the Federal Government for the building projects that are pending, and which are important requirements in a program of health care for our people. An increase of the allotment would certainly enable many hospitals that are already serving the population well to improve their service and to enlarge it more adequately to meet the needs of hospitalization.

In the State of New Jersey, in which I have served as administrator of a general hospital, the agency charged with the execution of the survey and construction plans reports that some 27 projects are under consideration as recipients of Federal aid. I am informed that other necessary works of enlargement and improvement are held in abeyance because of financial reasons. In the effort to provide the best health service for our people these projects should receive consideration and an increased allotment would undoubtedly have a stimulating effect.

Replacing the straight 33⅓-percent allotment with one based upon the State's allotment percentage would enable hospitals to receive aid in partial projects. In the instances of reluctance on the part of the approving agency to grant approval to a project, only part of which conforms to the stipulated requirements, there will be opportunity for limited assistance for the project to the extent of the acceptable portion of the proposal.

Scientific research has been proven a profitable activity in the several fields in which it has been applied. The world has benefited greatly from the results of studies and experiments of those who can devote time, energy, and money to projects that are beyond the scope of ordinary living. Hospital budgets do not ordinarily provide for research. It is expensive work and is too often left to the great philanthropic foundations which can afford to carry it on. The hospital's participation entails not only support of the personnel, professional and lay, to carry out the procedures but also provision of space and equipment necessary to the projects. In view of the fact that the ordinary hospital income is barely adequate to support the daily routine of therapy it is not surprising that little attention is given to research. It is, therefore, very evident that the provision of funds for research activity would enable hospitals to develop more adequately this important phase of service for the health of the populace.

Recognizing the importance of Federal participation in providing solutions to our health problems, we should bear in mind the obligations of local governmental divisions and those of individuals to care for their own needs. Grave concern is felt in some quarters regarding the encroachment of the Federal Government upon the domains of the States. On May 9, 1949, Governor Driscoll, of New Jersey, urged upon Congress the need of careful study of present and proposed tax systems. He said, "a restoration of tax bases to the States would immediately restore to many States the financial capacity of those States and their political subdivisions to meet their own responsibilities on the basis of free, local self-government."

It is the freedom of the people to choose the methods of arriving at desirable objectives that has characterized the successful progress of our Nation. In considering the national health bills there is universal agreement as to objectives but a difference of opinion as to methods.

At the twenty-seventh annual convention of the American Protestant Hospital Association, held in September 1948, the resolutions committee reported as follows:

"The resolutions committee views with alarm the reported activities re compulsory health insurance, health-aid control of medical care of our people and the discussion over the extent of Federal control of State and local health organizations against noncontrol, and the committee expresses the hope that matters relating to health and facilities to provide the necessary care for the sick may be approached from high humanitarian, broad economic levels and not from a partisan political one.

"The committee hopes that this vital matter of the health of our people may not become a political football to be bandied about by political parties. The committee welcomes the discussion by the press and the reports of the pros and cons by different individuals, groups, organizations, and governmental agencies of proposed governmental health programs.

"Without prejudice to plans which have been under discussion during the past year, the committee is of the opinion that no plan or policy should be adopted until the plan has been explored and approved by the joint committee of the American Hospital Association, the Catholic Hospital Association, and the American Protestant Hospital Association in conjunction with the American Medical Association, health agencies, and Government agencies.

"The combined findings of these organizations should be presented and made available to committees of the House of Representatives, the Congress, the President of the United States, and governmental departments.

"Whereas the good health of the men, women, and children of our several communities is the goal of our health agencies, including hospitals, and

"Whereas studies and surveys of recent date have indicated the necessity for concerted action in providing increased facilities, personnel, and finances in order to cope with the problems which confront hospitals, and

"Whereas in this democracy burdens are spread among the many and the strong support the weak, and

"Whereas great institutions of merciful help for the afflicted have multiplied in the land by reason of philanthropically minded men and women, and

"Whereas our democratic customs emphasize freedom with liberality: It is therefore

"*Resolved*, That the American Protestant Hospital Association record its approval of its officers and representatives in their efforts to effect and improve the systems of voluntary prepayment plans for the care of hospital patients and urges them to cooperate with other associations for the care of the sick wherein the people of our communities may freely choose the agencies for their care and the organized vehicles for periodic payments such as represented by Blue Cross plans for financing their care."

It is understandable that the attitudes and thinking of church hospital representatives would reach concurrence on hospital matters. We have studied the proposal of the Catholic Hospital Association, entitled "A Voluntary Approach to a National Health Program" and see in it a sound method of Government aid to the voluntary institutions concerned with the health of the Nation. The adoption of such a plan would accomplish the desired result without disrupting the traditional freedom which has been characteristic of our Nation's development from its very beginning.

We are fortified in our preference for a voluntary health insurance plan rather than a compulsory one in the remarkable achievement of the Blue Cross hospital plans and the Blue Shield medical and surgical plans.

In addition to the over 34,000,000 persons covered by Blue Cross hospital plans there are additional millions covered by hospital insurance companies, fraternal societies, commercial insurance companies, industrial and private group clinics, unversity health plans, and others that bring the total number of persons covered to 55,000,000.

The Blue Shield plans, as of March 31, 1949, had 11,333,758 persons enrolled. It is expected that the accelerated increase of enrollment in these organizations will rival the phenomenal growth of the Blue Cross plans.

The American people have never shirked responsibility. The very liberty they enjoy requires the acceptance of responsibility. They are capable of devising methods for their health needs without the compulsion of paternalistic government.

Gentlemen of the committee, we need and welcome your help and guidance in a voluntary health program.

Thank you for hearing this statement for the American Protestant Hospital Association.

Mr. PRIEST. The committee is happy at this time to hear Mr. Robert G. Carter, supervisor of the hospital planning division of the Florida State Improvement Commission.

Mr. Carter?

STATEMENT OF ROBERT G. CARTER, SUPERVISOR, HOSPITAL PLANNING DIVISION, FLORIDA STATE IMPROVEMENT COMMISSION

Mr. CARTER. Thank you, Mr. Chairman.

Because I understand that I am the only witness this afternoon, I will cut my statement short and emphasize only those points which I believe have not received the attention their importance deserves.

Mr. Priest. You would like to have your full statement included in the record, however?

Mr. Carter. Yes, sir.

Mr. Priest. It will be included.

(The prepared statement of Mr. Carter is as follows:)

Statement of Robert G. Carter, Supervisor, Hospital Planning Division, Florida State Improvement Commission

Mr. Chairman and members of the committee, I appreciate this opportunity to appear before you for the purpose of reporting the progress that we have made in Florida on our hospital construction program, and discussing with you several proposed amendments to the Hill-Burton Act now being considered by this committee.

In Florida we now have grants approved for 17 hospital and health-center projects representing a construction program of approximately $14,000,000.

Of these 17 projects, 1 has been completed and 9 are now under construction representing approximately $11,000,000 in contracts. All of these projects are in A and higher B priority areas.

During the past several weeks I have had an opportunity to study the testimony presented early last month before the Senate subcommittee which heard proposed amendments to our Federal Hospital Survey and Construction Act. During the course of these hearings several competent authorities impressed upon the committee the desirability of increasing the annual contractual obligation authority of the Surgeon General and the desirability of providing funds to make possible research experiments and demonstrations for the purpose of determining the possibilities of coordinating the services of hospitals.

In reviewing a preliminary list of those who were expected to testify before this committee I observed that several authorities who appeared before the Senate subcommittee were also scheduled for testimony before this committee. I presume that their recommendations to this committee will be the same as their recommendations to the Senate committee. I will, therefore, restrict my remarks primarily to two phases of the bills under consideration which I feel have not received the attention which they deserve in relationship to their importance to the continued fair and harmonious development of our program. During the Senate hearings little attention was given to the importance of extending the duration of the act over a sufficient period of time to allow effective advance planning.

Under the present act it appears that we will have sufficient funds to entertain applications from only A and high B priority areas in the State of Florida. There is real need for additional hospital beds in our low B and C priority areas; however, hospital groups in these lower priority areas, under the conditions of the present act, cannot plan hospitals or additions of existing hospitals with any degree of certainty. If the act is extended for a period of years we can give our lower priority areas some assurance of financial assistance, which assurance would enable prospective applicants in these areas to start planning now for projects expected to be placed under construction several years from now. May I remind the committee that usually from 1 to 2 years or more pass between the time a community definitely decides to build a hospital until the hospital is placed under construction. Bond elections must be held, bond issues validated, a site must be selected. financial studies must be made, preliminary plans must be prepared and studied, and second stage drawings and outline specifications thoroughly analyzed before the architect starts the long and laborious task of preparing detailed working drawings and contract specifications. After the final plans and specifications are thoroughly checked and construction estimates prepared, the architect must then advertise for bids and allow prospective bidders from 45 to 90 days to study the plans and specifications before bids are received. If, when bids are received, it is found that the cost of the proposed structure is in excess of available funds, the architect must rework his plans and specifications to reduce the cost of the project. Each step requires time.

House bills 3737, 2176, 2567, and 3025 propose to extend the program 4 years. Title III of H. R. 4312, and H. R. 4313 would extend the program to June 30, 1957. The longer extension proposed by H. R. 4315 and H. R. 4313 allows for more advanced planning.

The second point which I believe did not receive the attention its importance deserves in the discussions before the Senate subcommittee is the determination of the effective date for the increased grant percentage proposed by House bills 3737, 2176, 2567, 3025, and title III of House bills 4312 and 4313.

According to House bills 2176, 2567, and 3025 all grants approved after January 1, 1949, would be for that portion of the project cost equivalent to the State's allotment percentage. The allotment percentage of most States is greater than 33.33. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. As of January 1, 1949, construction grants had been approved for approximately 525 projects throughout the Nation. Of these 525 projects only 188 were under construction and only 10 actually completed as of January 1. According to the provisions of these three bills, grants for the 10 completed projects and those 188 projects which received final approval for the letting of contracts before January 1 would remain pegged at one-third of construction cost; and, depending upon the interpretation which may be given by the general counsel of the Public Health Service, the projects which had received preliminary approval before January 1, 1949, but which had not received final approval for the letting of contracts might also be placed in the same category. This would mean that communities which have exercised the greatest courage and initiative in creating a definite hospital program, floating bond issues, preparing plans, and which have placed their hospitals under construction at an early date would be penalized; and those communities which have exercised less courage and initiative and whose hospitals went under construction after January 1 or will not go under construction until some future date would receive grants in excess of one-third of construction costs.

It is felt most important that the increased grant percentage proposed by House bills 2176, 2567, 3025, and others be made retroactive to the beginning of the program in order that all communities building hospitas might share equally in the benefits of the program. If this were an old program, and if many hospitals had been completed under the provisions of the present act, it would be unreasonable to request that the new allotment percentage be made retroactive; however, since the program is so new with only 198 projects actually placed under construction throughout the Nation and only 10 projects completed in the entire United States before January 1, it appears only reasonable that the increased grant percentage be made applicable to all approved projects.

Should the Congress fail to make the proposed increased grant percentage applicable to those 198 projects approved before January 1 it would not only penalize these applicants for their courage and initiative in securing early approval but would also defeat the stated purposes of the program, the purposes being to secure a more even distribution of hospital care throughout the Nation by encouraging and assisting in the construction of "the necessary physical facilities for furnishing adequate hospitals, clinics, and similar services to all their people." This contention is substantiated by an analysis of the 198 projects approved before January 1, the grants for which projects would be pegged at one-third of construction costs by the provisions of H. R. 3176, H. R. 2567, H. R. 3025 and several other bills now being considered.

An analysis of these 198 projects approved for construction contracts before January 1, 1949, reveals the following:

(1) Of these 198 projects, only 10 small projects with grants averaging less than $71,000 each were completed before January 1, 1949.

(2) These 198 projects are distributed through 42 States.

(3) Over 80 percent of these 198 projects were approved during the last 6 months of 1948, and contracts were let when building costs were at a peak.

(4) These 198 projects were predominantly small rural general hospitals.

(5) These 198 projects were predominantly in A and high B priority areas; that is, those areas in greatest need of hospitals.

(6) The applicant's two-thirds of the construction costs of these 198 projects were raised predominantly through the issuance of bonds, revenue certificates and other types of indebtedness.

(7) Most important of all, the beds provided by these 198 projects approved before January 1, 1949, will provide only approximately one-fourth of the minimum bed needs in these A and high B priority areas, as defined by the State plans of the 42 States in which these early projects are located.

These early applicants, who have raised through public subscription the issuance of bonds, revenue certificates, and other types of indebtedness the two-thirds of the cost of planning, constructing and equipping these small hospitals have, in most instances, depleted their financial resources for many years to come. The size and design of the hospitals which they are building or have built were not determined by the needs of the community but by the ability of the community to raise two-thirds of construction cost.

If the proposed liberalized grant percentage is not made retroactive these 198 areas who have strained their financial resources to build small hospitals which meet only a fraction of their admitted minimum hospital needs will be frozen, with their small inadequate hospitals for many years. Few will be able to raise additional local funds to qualify for a second grant for enlarging their hospitals even under the liberalized grant percentage. However, if the effective date for the more liberal grant percentages is made retroactive these applicants will receive additional funds which may be used for enlarging these small hsopitals to more nearly meet their minimum community needs. They would then have in proportion to local funds involved, a hospital of a size and design comparable to those communities whose final applications were approved, or will be approved, after the arbitrary date January 1, 1949.

H. R. 3737 corrects this discrimination against projects approved before January 1 by stating August 13, 1946 (the date on which the present act became law), as the effective date for the more liberal grant percentages. This will allow the projects approved before January 1 to participate in the more liberal grants and thereby construct nursing wings to these small hospitals in order that they might more nearly meet the minimum hospital needs of the communities involved. These communities would then have in proportion to local funds involved hospitals of a size and design comparable to the communities whose final applications will be approved after January 1.

Mr. Chairman, may I give the committee several examples to show exactly what I mean?

1. The only project now completed in Florida is the Suwannee County Hospital, located in Live Oak. According to the nationally accepted formula (2½ beds per thousand population served) for minimum hospital needs, a rural area such as is served by the Suwannee County Hospital should have a 70-bed hospital. After several years of careful planning and by straining their financial resources, the people of Suwannee County were able to raise only two-thirds of the cost of building a 36-bed hospital, which provides this area with approximately 1.3 beds per thousand population, or approximately one-half of the admitted hospital needs of the area. Furthermore, in order to supply two-thirds of the cost of constructing this small hospital, it was necessary to delete from the original plans provisions for labor rooms, minor surgery, a nurses' residence, and other needed facilities. At present, the Suwannee County Hospital is finding it necessary to rent at a cost of $125 per month a residence to house their nursing and technical staff.

Had the grant for this project been for that proportion of construction costs now proposed by the several House bills now being considered, the people of Suwannee County would have been able to construct a hospital of a more adequate size and design. If H. R. 3737 is enacted, additional funds will be available to construct the much-needed facilities which were deleted from the original plans.

2. *South Florida Crippled Children's Hospital, Coral Gables.*—For the past 8 years the South Florida Children's Hospital Corp. was been raising funds for the construction of a much needed orthopedic hospital for the children of southeast Florida. When detailed estimates were received late last year for the construction of this hospital, it was evident that the funds of the hospital, plus the matching funds provided under the present act, were insufficient to meet the cost of building and equipping the hospital as planned. As a result, it was necessary to eliminate an entire 22-bed nursing unit intended for the treatment of poliomyelitis. Omission of this nursing unit reduced the capacity from 96 to 74 beds. Should the provisions of H. R. 3737 be enacted, the owners propose to complete the hospital as originally planned, including the nursing unit for treatment of poliomyelitis.

3. *Southeast Florida Sanatorium, Lantana, Fla.*—The 1947 Legislature of Florida appropriated $2,500,000 to be used by the State tuberculosis board in matching Federal funds for the construction of two critically needed tuberculosis sanatoria. When bids were received for a 400-bed sanatorium now under construction at Lantana, it became evident that the State tuberculosis board would have only sufficient funds to meet two-thirds of the cost of building and equipping this one sanatorium. This sanatorium, when completed, together with the existing santorium at Orlando, will provide less than one-half of the beds needed to care for tubercular patients in Florida.

Should the provisions of H. R. 3737 be enacted, thereby requiring the State tuberculosis board to supply only 42½ percent of the construction costs of this hospital instead of the 66⅔ percent as required by the present act, the board would then have a sufficient balance of unobligated funds in its State appropriation to match Federal funds on the basis of the proposed new grant percentage to construct a new 200-bed sanatorium in west Florida, which is the next project on the established construction program of the State tuberculosis board.

4. *American Legion Hospital for Crippled Children, St. Petersburg.*—For over 10 years the American Legion Hospital for Crippled Children, a nonprofit corporation, has been accumulating funds for the purpose of constructing a modern fireproof hospital to replace the present two-story wood frame converted residence which they have been operating as a crippled children's hospital for the past 20 years. Because of the nature of the patients served by this hospital, this two-story frame structure has been considered and declared a most serious fire hazard.

When bids were received for the construction of this new hospital, the corporation found that they did not have sufficient funds to defray two-thirds of the cost of constructing and equipping the hospital as planned. As a result, it has been necessary by three series of addenda to the specifications to eliminate facilities both necessary and desirable for the effective operation of a children's hospital to the extent of approximately $70,000 in order that a construction contract might be let. Actual construction has just been started. If the provisions of H. R. 3737 are enacted, the facilities which have been deleted from the construction contract could be reinstated and the hospital completed as originally planned.

5. *Florida A. and M. College Hospital and School for Nurses.*—The construction of this project is most important to all Florida hospitals in order that we might have a continuous supply of well-trained Negro nurses for the care of Negro patients. When bids were received for the construction of this hospital and nursing school, it was found that sufficient funds were not available to defray two-thirds of the cost of the project. As a result, Dr. William Gray, president of A. and M. College for Negroes, representing the faculty and student body, asked the State board of control to approve the issuance of revenue certificates to be retired by an infirmary fee which Dr. Gray proposed be levied against all students at A. and M. College for the next 20 years. This infirmary fee, when added to other existing fees, will be a real burden on the students of the A. & M. College. The project was finally approved and placed under construction only a few days before January 1, 1949. According to the provisions of House bills 2176, 2567, and 3025, had this project been approved and placed under construction after January 1, 1949, the issuance of these revenue certificates and the assessment of student fees would not have been necessary. Should the provisions of H. R. 3737 be enacted, it will not be necessary to execute the revenue certificates as proposed.

6. *Bay County Hospital, Panama City.*—Panama City is primarily a papermill community, the population of which has quadrupled during the past 20 years. Since 1940 the population of this community has more than doubled, primarily as a result of commercial and service activities during the war. It has been served by three small hospitals totaling less than 65 beds, 2 of which are converted frame residence buildings. For the past 7 years the people of Bay County have been trying to construct a community hospital. A 100-bed hospital was designed immediately before the war. After the war the cost estimates for this 100-bed hospital had increased to such an extent it was found impossible to raise sufficient funds to place the project under construction. New plans were prepared for a 60-bed hospital so designed that two 30-bed wings could be added at a later date. When bids were received on this 60-bed hospital, it was necessary that the board of county commissioners obligate over $70,000 of their general county operating funds for the next 3 years in addition to a 20-year bond issue in order to meet two-thirds of construction costs.

The population of this hospital service area is over 43,000 persons. To meet the minimum general hospital requirements of the area would require 173 general hospital beds. Because two of the small hospitals have recently been closed, this community will have upon the completion of the community hospital now under construction only approximately two beds per thousand population or approximately one-half of their minimum hospital needs.

If H. R. 3737 is enacted, a 30-bed wing and a most necessary nurses' residence can be added immediately. This community would then have in proportion to local funds involved a hospital of a size and design comparable to those communities whose applications for grant assistance are approved after January 1, 1949.

Mr. Chairman, I am in hopes that a study of these specific examples will impress the committee as to the importance of making the new grant percentages applicable to all projects in order that all communities building hospitals under this program might share equally in the benefits of the program.

Florida is not the only State concerned by the effective date for the proposed new grant percentages. Forty-two States had projects approved and under construction before January 1, 1949, representing approved grants of over $30,000,000. The Public Health Service has estimated that it would require approximately $23,000,000 to adjust all grants approved before January 1, 1949, to an amount equivalent to the State's respective allotment percentage. However, less than $23,000,000 would be required should the Congress choose to limit grants to a maximum of two-thirds of project costs.

Mr. Chairman, I earnestly recommend to the committee the provisions of H. R. 3737.

Thank you, Mr. Chairman.

Mr. Carter. The first point which I believe has not received the attention its importance deserves is the desirability of extending the program for a sufficient period of time to allow effectively advanced planning. It takes a community from 1 to 2 years from the time they decide to build a hospital until it actually goes under construction. Considerable time is involved in preparing plans and specifications, preparing the financial program, selecting the site, and taking bids. I believe that this point was well covered by several witnesses this morning so I won't dwell on this subject further.

Mr. O'Hara. Also the very important point of raising the money.

Mr. Carter. It is most important.

The second point which I believe has not received the attention its importance deserves is the determination of the effective date for the increased grant percentage proposed by House bills 3737, 2176, 2567, 3025, and title III of House bills 4312 and 4313.

According to House bills 2176, 2567, and 3025 all grants approved after January 1, 1949, would be for that portion of the project cost equivalent to the State's allotment percentage. The allotment percentage of most States is greater than 33⅓ percent. Projects approved before January 1, 1949, would receive only one-third of the total construction cost. As of January 1, 1949, construction grants had been approved for approximately 525 projects throughout the Nation. Of these 525 projects, only 188 were under construction, and only 10 actually completed as of January 1.

According to the provisions of these three bills, grants for the 10 completed projects and those 188 projects which received final approval for the letting of contracts before January 1 would remain pegged at one-third of construction cost; and, depending upon the interpretation which may be given by the General Counsel of the Public Health Service, the projects which had received preliminary approval before January 1, 1949, but which had not received final approval for the letting of contracts might also be placed in this same category. This would mean that communities which have exercised the greatest courage and initiative in creating a definite hospital program, floating bond issues, preparing plans, and which have placed their hospitals under construction at an early date would be penalized; and those communities which have exercised less courage and initiative and whose projects went under construction after January 1, or will not go under construction until some future date, would receive grants in excess of one-third of construction costs.

It is felt most important that the increased grant percentage proposed by the House bills now under consideration should be made retroactive to the beginning of the program, in order that all communities building hospitals might share equally in the benefits of the program. If this were an old program, and if many hospitals had been completed under the provisions of the present act, it would be unreasonable to request that the new allotment percentage be made retroactive; however, since the program is so new, with only 198 projects actually placed under construction throughout the Nation and only 10 projects completed in the entire United States before January 1, it appears only reasonable that the increased grant percentage be made applicable to all approved projects.

Should the Congress fail to make the proposed increased grant percentage applicable to those 198 projects approved before January 1, it would not only penalize these applicants for their courage and initiative in securing early approval but would also defeat the stated purposes of the program, the purposes being to secure a more even distribution of hospital care throughout the Nation by encouraging and assisting in the construction of "the necessary physical facilities for furnishing adequate hospitals, clinics, and similar services to all their people."

This contention is substantiated by an analysis of the 198 projects approved before January 1, the grants for which projects would be pegged at one-third of construction costs by the provisions of several bills now before this committee.

An analysis of these 198 projects approved for construction contracts before January 1, 1949, reveals the following—this is the crux of the entire argument, Mr. Chairman:

First, of these 198 projects, only 10 small projects with grants averaging less than $71,000 each were completed before January 1, 1949.

Second, these 198 projects are distributed through 42 States.

Third, over 80 percent of these 198 projects were approved during the last 6 months of 1948, and contracts were let when building costs were at their peak.

Fourth, these 198 projects were predominantly small rural general hospitals.

Fifth, these 198 projects were predominantly in A and high B priority areas; that is, those areas in greatest need of hospitals.

Sixth, the applicant's two-thirds of the construction costs of these 198 projects were raised predominantly through the issuance of bonds, revenue certificates, and other types of indebtedness.

Seventh, and most important of all, the beds provided by these 198 projects approved before January 1, 1949, will provide only approximately one-fourth of the minimum bed needs in these A and high B priority areas, as defined by the State plans of the 42 States in which these early projects are located.

Now, if I might digress for a moment, Mr. Chairman, from my written statement, the point was raised this morning that fewer hospitals would be built if the Federal grant percentage was increased, and several witnesses testified that so far in the program high-priority areas were finding it possible to raise two-thirds of construction costs and were making applications for construction grants.

It is true that high-priority areas are making applications and are building hospitals, but this analysis shows what they are building. According to the rules of the program we must give A priority areas the first opportunity to secure Federal grant funds because A priority areas are the communities in the greatest need of hospital facilities. All A priority areas need and want to build hospitals, so early in the program many of these communities raised what funds they could, secured grants, and placed hospitals under construction. Approximately one-fourth of A priority areas now have projects approved, but the hospitals which they are building are not meeting the needs of their communities. The approved projects in high-priority areas are meeting an average of about one-fourth of the minimum hospital needs in the community. In other words, a community needing a 100-bed hospital is taking what funds they can raise and securing a grant for the construction of a 25- or 30-bed hospital. This is characteristic of the early applications throughout the Nation under our program.

These early applicants who have raised, through public subscription, the issuance of bonds, revenue certificates, and other types of indebtedness, two-thirds of the cost of planning, constructing, and equipping these small hospitals have, in most instances, depleted their financial resources for many years to come. The size and design of the hospitals which they are building, or have built, were not determined by the needs of the community but by the ability of the community to raise two-thirds of construction cost.

If the proposed liberalized grant percentage is not made retroactive, these 198 areas who have strained their financial resources to build small hospitals which meet only a fraction of their admitted minimum hospital needs will be frozen with their small, inadequate hospitals for many years to come. Many have bonded themselves for 20 years to raise two-thirds of construction costs. Few will be able to raise additional local funds to qualify for a second grant for enlarging their hospitals, even under the liberalized grant percentage, until their original bonds have been retired. However, if the effective date for the more liberal grant percentages is made retroactive, these applicants will receive additional funds which may be used for enlarging these small hospitals to more nearly meet their minimum community needs. They would then have, in proportion to local funds involved, a hospital of a size and design comparable to those communities whose final applications were approved, or will be approved, after the arbitrary date, January 1, 1949.

H. R. 3737 corrects this discrimination against projects approved before January 1 by stating August 13, 1946, the date on which the present act became law, as the effective date for the more liberal grant percentages. This will allow the projects approved before January 1 to participate in the more liberal grants and thereby construct nursing wings to these small hospitals in order that they might more nearly meet the minimum hospital needs of the communities involved. These communities would then have, in proportion to local funds involved, hospitals of a size and design comparable to the communities whose final applications will be approved after January 1.

Mr. Chairman, may I give the committee several examples to show exactly what I mean?

The only project now completed in Florida is the Suwannee County Hospital, located in Live Oak. According to the nationally accepted formula, that formula being 2½ beds per thousand population served, for minimum hospital needs, a rural area such as is served by the Suwannee County Hospital should have a 70-bed hospital. After several years of careful planning and by straining their financial resources, the people of Suwannee County were able to raise only two-thirds of the cost of building a 36-bed hospital, which provides this area with approximately 1.3 beds per thousand population, or approximately one-half of the admitted hospital needs of the area.

Furthermore, in order to supply two-thirds of the cost of constructing this small hospital, it was necessary to delete from the original plans provisions for labor rooms, minor surgery, a nurse's residence, and other needed facilities.

At present, the Suwannee County Hospital is finding it necessary to rent, at a cost of $125 per month, a residence to house their nursing and technical staff.

Had the grant for this project been for that proportion of construction costs proposed by the several House bills now being considered, the people of Suwannee County would have been able to construct a hospital of a more adequate size and design. If H. R. 3737 is enacted, additional funds will be available to construct the much-needed facilities which were deleted from the original plans.

Example No. 2: South Florida Crippled Children's Hospital in Coral Gables. For the past 8 years, the South Florida Children's Hospital Corp. has been raising funds for the construction of a much-needed orthopedic hospital for the children of southeast Florida. When detailed estimates were received late last year for the construction of this hospital, it was evident that the funds of the hospital, plus the matching funds provided under the present act were insufficient to meet the cost of building and equipping the hospital as planned. As a result, it was necessary to eliminate an entire 22-bed nursing unit intended for the treatment of poliomyelitis cases. Omission of this nursing unit reduced the capacity from 96 to 74 beds. Should the provisions of H. R. 3737 be enacted, the owners propose to complete the hospital as originally planned, including the nursing unit for treatment of poliomyelitis.

I will omit several of these. I have example after example of specific projects, and they are not only characteristic of Florida; they are characteristic of the Nation. I have talked with administrators from other States, and am convinced of this.

Let me take the case of our Bay County Hospital, at Panama City. Panama City is primarily a paper mill community, the population of which has quadrupled during the past 20 years. Since 1940, the population of this community has more than doubled, primarily as a result of commercial and service activities during the war. It has been served by 3 small hospitals totaling less than 65 beds, 2 of which are converted frame residence buildings. For the past 7 years, the people of Bay County have been trying to construct a community hospital. A 100-bed hospital was designed immediately before the war. After the war, the cost estimates for this 100-bed hospital had increased to such an extent that it was found impossible to raise sufficient funds to place the project under construction. New plans were prepared for a 60-bed hospital so designed that two 30-bed wings could be added at a later date. When bids were received on this 60-bed hospital, it was necessary that the board of county commissioners obligate over $70,000 of their general county operating funds for the next 3 years in addition to a 20-year bond issue in order to meet two-thirds of construction costs.

I won't read the balance of this case, but it is obvious that if the proposed increase grant percentage is made retroactive, this community can add a 30-bed nursing wing. They would then have about half of the admitted bed needs of the community, and would have a hospital, in proportion to local funds involved, equivalent to a community whose grant is approved later during the course of our program.

Florida is not the only State concerned by the effective date for the proposed new grant percentages. Forty-two States had projects approved and under construction before January 1, 1949, representing approved grants of over $30,000,000.

Mr. O'HARA. Pardon me, Mr. Carter. How many was that? I did not catch the figure.

Mr. CARTER. There were 198 projects approved before January 1 in 42 States, representing grants of approximately $30,000,000.

The Public Health Service has estimated that it would require a little less than $23,000,000 to adjust all grants approved before January 1, 1949, to an amount equivalent to the State's respective allotment percentages. However, less than $23,000,000 would be required, should the Congress choose to limit the grants to a maximum of two-thirds of project cost.

The entire problem is just this, Mr. Chairman. We first entertained applications from A priority areas. They are the areas in greatest need of hospitals, and the areas of lowest economic income. The reason these communities did not have hospitals 10 years ago is because they could not afford them. Every community wants a hospital. When these communities found that they were eligible for these grant moneys, having wanted hospitals for years, they raised what money they could, bonded themselves to their legal limit, and then retained an architect to design their hospitals. As a result the design of these hospitals was not determined by the needs of the communities but were determined by the amount of money that the community was able to raise.

In Florida all of our approved grants to date are from A and high B priority areas. None of these projects are designed to meet the full needs of the community. For this reason, we have insisted that the architect design these hospitals in such a way that nursing wings could be added at a later date.

These early applicants needed and wanted hospitals badly. They had courage and initiative. The junior chambers of commerce and other groups of young men in the communities promoted most of these projects and got them under way at an early date. Now these groups of energetic young community citizens fear that they will be penalized for their initiative. They believe that if they had postponed the projects their communities would have secured greater grants which would have given the community a more adequate hospital in proportion to local funds involved.

If the projects had been built to meet the needs of the community this feeling would not exist and there would be no excuse and no justification for making the proposed grant percentage retroactive. This, however, is not the case. I have shown that the 198 projects approved before January 1 meet only about one-fourth of the minimum needs of their respective communities. It is obvious that if we don't make the proposed increased grant percentage retroactive, we are going to leave these high priority communities with hospitals meeting only one-fourth of their admitted need pegged with their small hospitals for years to come. In the future our applications will come more and more from low B and C priority areas, that is, areas that already have approximately 50 percent of their needs met by existing facilities. The result will be that we will give these lower priority areas increased grants to build to 100 percent of their hospital needs and leave the high priority areas with hospital facilities meeting approximately 25 percent of their need until they can retire their bonds.

It has been suggested during the course of this hearing that these early applicants could ask for a second grant to enlarge their inadequate hospitals. This will happen in very few instances. When a community has bonded itself to its legal limit to furnish two-thirds of the cost of constructing its original hospital, it is not likely that additional local funds could be raised to match a second grant for enlarging their hospital even with the proposed more liberal grant percentage.

Mr. O'Hara. Mr. Carter, this is the thing that troubles me about the matter of increase, to whatever extent it might be increased, if any, over the present contribution of 33⅓ percent. We will take the case of these hospitals that are built or are under construction, or are being built under this program. Then let us say it was increased to 40 percent or 50 percent, or whatever it might be, as a matter of a Federal contribution. Of course, the greater majority of those would be discriminated against, because if they could have gotten 50 percent they would have built that much more hospital. But having built under the 33⅓ percent, they have gone their limit.

I have at least two communities in my district where that is exactly what has happened.

Now, my point is this, Mr. Carter: There is no way of them coming back and coming in for the additional percentage. I mean, it just would not work out in a practical way. They could not contribute an addition which would be required. They are going to claim discrimination. Is that not true?

Mr. Carter. I should think that they would all wish that their State agencies had not encouraged them to get their applications approved so soon; that they would wish they had waited a little longer; and that they would feel like they had gotten the little end of the horn. And that would be true.

Mr. O'Hara. That is what troubled me. And I enthusiastically supported, as this entire committee did, this hospital building program. I think it has been a fine thing. But on the other hand, if we go to changing the contribution, there is a very just cry of discrimination or unfairness that is going to come back at us; much as I appreciate the argument which you have made with reference to this situation, which I think you would be frank to admit would be a discrimination against those who have already embarked on this hospital program.

Mr. Carter. It would be. It is recommended that we make the grants in each State equivalent to the State's allotment percentage, with some maximum of, say, 50 percent, or 66⅔ percent; and since there were so few projects approved before January 1, that these early applicants be made eligible for the increased grants. Then everyone would be treated alike, and these smaller communities that have gone ahead would then be able to construct additions to their hospitals. They would then have, in proportion to local funds involved, the same size hopsital as the new applicants.

Mr. PRIEST. Will the gentleman yield for a question at that point?

Mr. O'HARA. Yes, surely.

Mr. PRIEST. That presents a question to my mind. You have referred to a number of communities, and I know it is true across the country, that have exhausted their potentialities insofar as local finance is concerned, bonding themselves to the limit of their authority to do so under existing law in that particular section. Now, assuming we increase the Federal percentage to, say 50 percent, they have already exhausted their local finances for hospital construction. If there is any addition made to that hospital under a more liberal allowance of ederal funds, is it not true, Mr. Carter, that the community would still have to match those funds in order to be eligible for that, and that they would still have to go beyond what at present seems the point of exhaustion?

Mr. CARTER. No, sir. If the increased grant percentage is made retroactive the applicant will have already matched the increased grant. As an example: A community is now building a 30-bed hospital costing $300,000 for which a grant was approved before January 1 for $100,000, or one-third of the total cost. The community has raised $200,000 in local funds. If we increase the grant percentage from one-third of the project cost to 50 percent of the project cost and make the increase retroactive to the beginning of the program, the grant would then be increased from one-third of the project cost, or $100,000, to one-half of the project cost, or $150,000, requiring no additional funds to be raised by the applicant. The applicant could then use this additional $50,000 in grant funds for enlarging their hospital to more adequately meet the minimum needs of the community.

Mr. O'HARA. Let me just illustrate the same question that has been bothering me, that Mr. Priest just asked you about.

In our State we have a debt limitation for municipalities. In two communities in my district, I know, they went their bond limit and only by use of private subscription were they able to build the type of hospital that they wanted and that they needed. The cost of construction was terrific. They had reached the maximum of what they can vote in the way of bonded indebtedness of the municipality.

Now, if we increased this amount, how in the world could those municipalities come back and increase that? Because they have already reached the limit to which they could go.

Mr. CARTER. The proposal is, sir, that all projects approved before January 1 for one-third of construction costs be allowed to participate in the increased grant percentage proposed by the bills now being considered. The grants for these projects would then be increased to the State's allotment percentage with a maximum of two-thirds or 50 percent of the project cost, as might be determined by the Congress. These early projects would then receive the difference between their presently approved grants of one-third and the increased grants of, say 50 percent, without additional matching funds on the part of the local community.

Mr. O'HARA. That is, the difference between 33⅓ and 50 percent?

Mr. Carter. Yes, sir. The community would then receive the difference between one-third of the project cost and 50 percent of the project cost.

Mr. O'Hara. If they made application for it.

Mr. Carter. Yes, sir.

Mr. Priest. If it was made retroactive, they would receive that as if it had been in effect originally.

Mr. Carter. That is right, sir. So it would require no additional funds on the part of the local community.

Mr. O'Hara. But let me ask you this question. You have a matter that I suppose could be called discrimination in these A priorities which were allowed in each of the States under the studies, where they said: "This community is an A community, because it has no hospital facilities in the surrounding territory. Therefore, it should be an A community." Of course, there is bound to be in every State, no matter how fair and able the administrator is, a difficulty in saying, "This community is an A community," and in saying that another community is a B community.

Mr. Carter. No, sir.

Mr. O'Hara. Well, I mean by that: The one that has been designated as a B community may feel it was an unjust determination.

Mr. Carter. I don't believe that is the case for this reason: The present law states exactly how these priorities are determined. They are determined mathematically on the basis of the number of existing beds per thousand population within the hospital service area. The fairness of the method used for determining priorities has never been questioned in Florida or any other State that I know of. If the priorities were not determined by a mathematical formula they probably would be questioned. The population of an area and the number of existing beds in an area is a matter of record.

Mr. O'Hara. Except that that formula might not be entirely fair. You might have one community which is an unusually healthy community, and another community which is subjected to climatic conditions, or something, whereby it would not be so healthy. I say that situation could well arise too, Mr. Carter.

Mr. Carter. Possibly. However, it has been my impression that the health of the community is more related to the economics of the community than it is to the climate. That is possible, however.

Mr. O'Hara. I realize what you say, Mr. Carter, is true. But the point I was getting at was that it is going to be so difficult to spread these funds out fairly. I mean, obviously the Congress does not have money enough to appropriate to build hospitals in every community where they want a hospital and need a hospital. It is a matter of relativity and apportionment, I presume. I mean, in almost anything we try to do, unless we just say, "How many billions do we need for this program?" we get to that point. If we run into a falling off of taxes and Federal income, we, as a practical problem, in the committee, face the matter of selling to the House any increase in the amounts. That was one of the problems we had, Mr. Carter, when we considered this bill originally. Everybody said, "Well, this is a grand idea, and we are very hopeful," and I think the committee unanimously supported it enthusiastically on the floor, over some opposition, as I recall it. It was the very problem that is being presented to us in these bills: that if it was $325,000,000, all right; but some expressed themselves as being concerned that immediately there would be this demand for further help. And maybe it would be necessary to give this further help and increase the amount. I do not know where we are going to end. I will cite my own personal problem, as one who was enthusiastically for this bill which was passed in the Seventy-ninth Congress.

I have not been here to attend some of these hearings, because of other committee hearings that I have had to attend, but what is the limit to which we can go on this program, no matter how much we appreciate what a fine thing it has been?

Mr. CARTER. I believe at the rate we are now going, it would require approximately 50 years to build the hospitals that are needed. This is not a problem that will be solved in a short time.

Mr. O'HARA. Of course the cost, then, depends upon what the construction costs are. And presently they are very high. That is true, is it not? Some communities have been reluctant to proceed with hospital programs because of that.

What is your experience in Florida as to those you have constructed, Mr. Carter? Have they run above the original estimates considerably?

Mr. CARTER. No, sir. Our estimates were based on current construction costs. Our projects are costing a little more than $10,000 per bed, which is less, I believe, than the average for the Nation.

Mr. O'HARA. I would say it was quite a bit less than up in a cold climate like in my home State of Minnesota.

Mr. CARTER. This is completely equipped, total cost, ready for operation.

Mr. O'HARA. Well, for one thing, you do not have to build them for severe cold weather, do you? I mean, that is one item of cost you do not have to consider?

Mr. CARTER. Not as much so, I would suppose, as in the Northern States.

Mr. O'HARA. I did not mean to divert you from your argument, but the problem which bothers me is what I have outlined to you: That no matter how strongly we on the subcommittee may feel as to increasing the amounts, increasing the proportions, and so forth, I am afraid we are running rapidly into a problem of salesmanship on the floor.

Mr. PRIEST. Mr. Sadowski?

Mr. SADOWSKI. No questions.

Mr. PRIEST. Mr. Wilson?

Mr. WILSON. I have none.

Mr. PRIEST. Mr. Carter, we appreciate very much your statement. This subcommittee has studied this question and will continue to study it pretty carefully and thoroughly.

I can concur in what Mr. O'Hara has said about the problem of salesmanship. We who have been familiar with this problem from the beginning, regardless of our enthusiasm, as he expressed it, when we take it to the floor of the House and to a group of men who have not had that enthusiasm engendered as we have because of being close to the subject, have a terrific selling job to do there, particularly when an economy wave hits, as is now under way.

Just one other question on this retroactive phase of the program, which we all agree is a pretty difficult one: You heard the testimony this morning, in which it was disclosed, I believe, that there are about 55 hospitals, as I think was the figure, that are partly constructed, that have not been included in State plans, and yet the communities in which these hospitals are located feel that they have reached their limit, and that they cannot go any further and that they might be included by a retroactive provision of this bill, although not presently included in State plans.

I wonder if you have any comment on that retroactive element?

Mr. Carter. I understood the question a little differently. From the information that the gentleman gave, I believe that he referred to some fifty-odd projects over the Nation that are what we call pick-up projects; that is, projects which were started before the State agencies were in a position to entertain applications and for which grants were approved during the course of construction for one-third of the cost of completing the project. We had a project in Florida which was started before we completed our State plan. The community did not have sufficient funds to complete the hospital. A grant was approved for one-third of the cost of completing the construction of the hospital and equipping the hospital. The point brought out by the witness this morning, as I understood it, was that he wanted the law changed in such a way that a grant could be approved for one-third of the total cost of the project instead of the cost of completing the project.

Mr. Priest. Is that right?

Mr. Carter. That is correct; yes.

Mr. O'Hara. Mr. Carter, does your State contribute also to the hospital program?

Mr. Carter. No, sir; it is my understanding that there are four States that contribute substantially to the program, and then several others that contribute a very small amount to the program.

Mr. O'Hara. Does Minnesota contribute?

Mr. Carter. Not to my knowledge, sir.

Mr. O'Hara. My recollection was that they did not.

Mr. Wilson. Will the gentleman yield?

Mr. O'Hara. Yes.

Mr. Wilson. What are those four States?

Mr. Carter. Mississippi, North Carolina, Georgia, and I believe Michigan, sir. However, I understand that the Michigan program has about terminated. I believe it was Michigan that had some four or five million dollars appropriated by their State legislature. It is my understanding that when this appropriation is expended there is no assurance that additional money will be provided.

There are several other States that have made very small State appropriations. These small appropriations are of little significance.

Mr. Wilson. What are those funds used for? Administrative purposes?

Mr. Carter. No, sir. In Mississippi, North Carolina, and Georgia Federal grants cover one-third of construction costs, a State grant covers a substantial portion of the construction cost, and the community raises the balance.

Mr. Wilson. You heard the proposal this morning to make it on a 50–50 basis for administrative purposes. What do you think of that?

Mr. Carter. I have mixed feelings toward it, sir.

Mr. Wilson. I thought so.

Mr. Carter. Some of the States are having difficulty in raising administrative funds, and still I think if the program is to be administered by the State and we are to maintain State control, we would do well to use entirely State funds for administrative purposes.

Mr. WILSON. Would that tend to bring about a better State-level administration?

Mr. CARTER. At the present time, the administration of the program is left entirely up to the States and the States must provide the total cost of administering the program.

Now, if, through the years, we want to keep it that way, it would probably be well to have the State furnish the salaries and the expenses of administering the program. If we use Federal funds to pay salaries and administer the program in the States, it is conceivable that at some time in the future, the State might not have full control of the administration of the program.

Mr. PRIEST. Any further question, Mr. Sadowski?

Mr. SADOWSKI. I do not think I have any questions.

Mr. PRIEST. Mr. Wilson, do you have any further questions?

Mr. WILSON. I did not get the real reasons, Mr. Carter, as to why you were not able yet to get down to other priorities. You say in Florida it is A and B priorities that you are working on now. Is that right?

Mr. CARTER. That is right, sir.

Mr. WILSON. It is lack of funds, just lack of funds?

Mr. CARTER. Yes, sir. We must first offer our available grant funds to A priority areas. If all of our State allotment of Federal grant funds is not used by projects in A priority areas we may then entertain applications from B priority areas. To date we have not had sufficient funds to entertain applications lower than our middle B priority areas. We will be able to go lower on our priority scale only as further Federal funds become available.

Mr. WILSON. I gathered from the testimony this morning, Mr. Carter, from what was submitted by the Deputy Surgeon General, Dr. Dearing, that among the top priority, the highest priority areas, taking it Nation-wide, there are many of them that are not even submitting applications that cannot and do not.

Mr. CARTER. That is true, sir. And those high priority areas that are making application are building hospitals that meet only a small fraction of their community needs. In other words, a community that needs a 100-bed hospital is finding it impossible to raise more than two-thirds of the cost of building only a 25- or 30-bed hospital. In fact, all the projects approved in the United States before January 1 meet only approximately one-fourth of their community needs.

Mr. WILSON. Do you folks that are in the planning of hospital construction, and so forth, of the State health departments of the various States, have a clearinghouse of information, or do you use only the Public Health Service?

Mr. CARTER. What information, sir?

Mr. WILSON. A clearinghouse where you learn of the surveys in other States. Do you know what is going on in other States?

Mr. CARTER. Yes, sir. Most of the administrators of the State programs meet annually with the American Hospital Association and the American Public Health Association. There we discuss what we are doing and we exchange information. I send copies of all bulletins that we prepare in Florida to the other State agencies. In return, I get a continuous stream of bulletins from the other States.

Could I make one further observation, Mr. Priest?

Mr. **Priest**. Yes, sir; you may.

Mr. **Carter**. Earlier during this hearing a fear was expressed that if we raise the allotment percentage very high, communities might build hospitals larger than they are able to support. I see no danger of this happening. The first 198 projects approved throughout the Nation were for hospitals meeting only approximately 25 percent of their minimum community needs.

When I first heard this fear expressed at a national meeting I was concerned over the possibilities of our grant-in-aid program encouraging communities to build hospitals larger than they were able to staff and support, resulting in new hospitals closing for the lack of operating funds. However, on further consideration it occurred to me that I knew of no community hospital that had ever closed for the lack of financial support. Further, during the past 2 years I have asked many hospital administrators and national authorities on hospital planning to name for me community hospitals which to their knowledge had closed for the lack of operating funds. To date I have found no one who has known of a community-supported hospital to close for the lack of funds. I do not deny that there have been no such instances. Surely some have closed under such circumstances. However, there are no such cases in Florida. There must have been few in the other States.

In my questioning I have learned of several cases where the ownership of a hospital was changed because of financial difficulties. I have in mind several instances where municipal hospitals have been transferred to county governments for operation. I also have knowledge of several small proprietory hospitals that have closed under various circumstances. However, these hospitals are not public or nonprofit hospitals supported as such by their communities.

It is true that some of our large teaching hospitals in the Nation are in a rather serious financial condition. These teaching hospitals have little income from patients. They are large hospitals which require many millions of dollars annually for operational purposes. During the past years they have depended on sources of income other than those which are usually available to small community hospitals.

I wanted to discuss this point because of the fear that was expressed this morning that if we raise the allotment percentage we might encourage communities to build hospitals a little beyond their ability to operate. Because I have never been able to learn of a single hospital that has been closed for the lack of operating funds, I believe this question is rather academic and I can see no danger from this standpoint in increasing the grant percentage to the extent proposed by the bills now being considered.

Mr. **Wilson**. You do not believe they would be over-ambitious, nor would they overbuild?

Mr. **Carter**. The first 198 projects approved throughout the Nation under our program were for hospitals meeting approximately one-fourth of the community needs, as defined by their respective State plans. Had these first 198 hospitals averaged twice the size that they are now being built they would meet only approximately 50 percent of the community needs. Their size could be increased by four times before they would average meeting 100 percent of community needs.

Mr. **Wilson**. Of course, one of the things he was referring to, as to their being too ambitious, was the maintenance, the carrying on of the hospital, as well as the staffing of it.

Mr. Carter. That is the reason I brought out the point that I know of no hosiptal in the United States, and have been unable to learn of any hospital, that has ever closed for the lack of operating funds. There may be some, and I don't deny that there are, but I have never been able to have any man point me out a case. And I have asked that question of many, many persons in hospital fields throughout the Nation for the last 2 years.

Mr. Wilson. You are of the opinion, then, that the 40 percent referred to by the gentlemen from the hospital association is too small.

Mr. Carter. Yes, sir.

Mr. Sadowski. Now, following your argument that it would take 50 years to develop the hospital program so as to meet the needs of the Nation, would it not also be logical to say that the 55 projects that were referred to by the man from Michigan have merit and should be completed, and that there probably is need for each one of those 55 projects? And so if the act was made retroactive so as to include all of them, they would serve the varying needed purposes?

Mr. Carter. I believe it would, sir. As an example, we have in Florida a community in need of a hospital which has over $100,000 invested in an incompleted hospital which is now standing with the windows boarded up. It is no service to anyone. The community has invested in this partially completed structure all of the funds that they were able to raise. Now they find that they cannot raise two-thirds of the cost of completing the hospital. We could under the present law and would secure a grant for them for one-third of the cost of completing the hospital if they were able to raise the balance of the money that would be necessary to complete and equip the hospital as planned.

Mr. Priest. I talked with representatives of the Public Health Service after the session this morning, and as you all recall, we asked them to go into a huddle, so to speak, to see what sort of provision they might work out on this retroactive feature, and they have agreed to do so. I am hopeful that we can work out a provision that will be equitable and that will not open up the door and constitute too much of a departure from all of our other Federal aid programs. If we consider the Federal aid for highways program, we run into a somewhat similar situation, and in every field where we furnish Federal aid, we run into that retroactive phase of the program, which is pretty difficult to handle. But I believe that the subcommittee, working on it, with scome assistance from the agency and men such as you, Mr. Carter, can work out something on this that will be extremely helpful.

Mr. Wilson. Mr. Chairman, let me ask, for my own information, as to my own particular community:

I take it you are the gentleman in charge of that section of your Florida Health Department that does the planning of hosiptals under the Hospital Construction Act.

Mr. Carter. I have charge of the hospital program in Florida, but Florida is one of the few States in which the program is not administered by the State board of health. It is administered in Florida by the Florida State Improvement Commission. I do have charge of the administration of the program.

Mr. Wilson. You have charge of surveying and reevaluating annually, or earlier, the State plans.

Mr. Carter. Yes, sir.

Mr. Wilson. Let me assume a situation here, and see what the answer is. Here is a community, under your plan you say, that is not in the priority of A and B, that may be down here in C or D. They believe that there is a real need for the increase in their present small facilities. They believe there is a need there, and they tell you they will raise half a million dollars. I am trying to give you the facts as to one of the communities in my own district. They raise half a million dollars cash, and they propose to build a three-quarters of a million dollar addition and add so many beds for the various departments. Yet can they get that approved? Can they get an approval of that particular project, so that they can get State aid to supplement that half million dollars, and get another quarter of a million to add to it, when they are in a priority of C or D, rather than A or B, and when in that same district of that particular State the A priorities are not calling for it, because they do not have the incentive or the initiative or the need to acquire the necessary percentage of matched funds?

Mr. Carter. If the funds are not consumed by projects in A or B priority areas, the State agency can go down their priority chart and approve projects from C and D priority areas; but it can't approve a grant for a C priority area if there are applications pending in higher priority areas.

Mr. Priest. If those that are pending call for the expenditure of all allocated funds, they could approve one in C if they had already approved all applications in a higher priority group.

Mr. Carter. Yes, sir.

Mr. Priest. And still have allocable funds.

Mr. Carter. That is right, sir.

Mr. Wilson. However, that has been going on for the last couple of years, and they have only reached a lot of A's and B's and in your State they are only down to the middle of the B priority.

Mr. Carter. Yes, sir.

Mr. Wilson. Is there a way of reaching that situation, where for a period of 2 years one of the Catholic sister organizations has accumulated funds both by gifts and fund raising and by outside finance, and have all the detailed plans and specifications for an addition, but cannot proceed?

Mr. Carter. It is because the State agency does not have sufficient Federal funds. If there were sufficient funds, your State agency could go right on down the priority chart and approve grants for as many hospitals as available funds would permit. But first choice of funds must be given to A priority areas.

As I have explained before, the priority of each area is determined by a mathematical formula. This formula expresses the relationship between the population of an area and the number of existing beds in the area. A community that has over one-half of its need met by existing facilities would very likely be designated in most State plans as a low B or C priority area. If a community needs a 200-bed hospital and has in operation a 100-bed hospital, one-half of its need is met by this existing hospital; whereas if a second community needs a 100-bed hospital and has no existing hospital this community would have an A priority because none of its need is met by an existing hospital. This second community would have preference over the community that had a 100-bed hospital in operation.

Mr. Wilson. Maybe it is the same old story. The mills of the gods grind slowly, but they grind exceedingly fine, and it has gotten so in the last few years that it has not reached those, and yet a lot that are in the A group, as Dr. Dearing testified this morning, are not calling for it, either because of lack of initiative or lack of need.

Mr. Carter. If few A priority areas make applications for grants your State agency will have enough funds to entertain applications from B priority areas. If no B priority projects are ready for construction your State agency could then entertain applications from C priority areas. The likelihood of a low-priority project being approved is depending on two factors, the number of higher priority projects that are ready for construction and the amount of Federal-grant funds available to the State agency.

Mr. Wilson. According to the information elicited from Dr. Dearing, that is the case.

Mr. Priest. We thank you very much for a very helpful statement and analysis, Mr. Carter.

The committee will stand in recess until 10 o'clock July 6.

(Whereupon, at 3:30 p. m., the committee recessed, to reconvene at 10 a. m., Wednesday, July 6, 1949.)

#25a

NATIONAL HEALTH PLAN

WEDNESDAY, JULY 6, 1949

House of Representatives,
Subcommittee of the Committee on
Interstate and Foreign Commerce,
Washington, D. C.

The subcommittee met at 10 a. m., pursuant to adjournment, in room 1334, New House Office Building, Hon. J. Percy Priest (chairman of the subcommittee), presiding.

Bills considered: H. R. 4312 and H. R. 4313 (identical bills)—national health, with respect to Title V—Grants to States for State and Local Health Work.

H. R. 4918, H. R. 4919, H. R. 4920, H. R. 4921, H. R. 4922, H. R. 4923, H. R. 4924, and H. R. 5087 (identical bills)—national health.

H. R. 267, by Mr. Priest and H. R. 785, by Mr. Dolliver—to assist the States in the development and maintenance of local public-health units, and for other purposes.

Mr. Priest. The committee will come to order.

We have before us today a number of proposals that would furnish better aid to the States for local public health service.

Included in this group are the bills, H. R. 267, H. R. 785; also title V of the bills, H. R. 4312 and H. R. 4313, and related provisions of the bill, H. R. 4918, and a number of identical companion bills proposing a national health service.

We are pleased to have Dr. Palmer Dearing, the Acting Surgeon General of the Public Health Service as our first witness this morning. Dr. Dearing, will you come forward.

STATEMENTS OF DR. W. PALMER DEARING, ACTING SURGEON GENERAL; DR. J. W. MOUNTIN, ASSISTANT SURGEON GENERAL, ASSOCIATE CHIEF, BUREAU OF STATE SERVICES; AND DR. HARALD M. GRANING, SENIOR SURGEON, CHIEF, STATE AND LOCAL HEALTH SERVICES BRANCH, DIVISION OF STATE GRANTS, BUREAU OF STATE SERVICES, UNITED STATES PUBLIC HEALTH SERVICE, FEDERAL SECURITY AGENCY, WASHINGTON D. C.

Dr. Dearing. Mr. Chairman and members of the committee, I appreciate the opportunity to appear before the committee in behalf of this very important legislation, and I should like, with your permission, to introduce Dr. J. W. Mountin, Assistant Surgeon General, Bureau of State Services, and Dr. Harald M. Graning, of the State and Local Health Services Branch of the Division of State Grants, Bureau of State Services, to assist me in presenting the details of the testimony.

Mr. PRIEST. Thank you. We will be very happy to have your colleagues and associates here, and they are not strangers to this committee. You may proceed.

Dr. DEARING. The current interest in the expansion and improvement of local health services has grown to such a point that there are now 65 national organizations supporting legislation which would make available good local health service to every American community.

The Public Health Service has repeatedly stressed the importance of establishing good local health service throughout the Nation. We are therefore gratified that this proposal now has the unqualified support of such organizations as the National Congress of Parents and Teachers, the National Health Council, and the many consumer-interest organizations that comprise the National Advisory Committee on Local Health Units. We welcome the opportunity to express our wholehearted support for the general objectives of the bills before you.

I should like to address the first part of my statement to a discussion of the national situation as far as local health services are concerned—to the needs of those local health departments that are struggling along in spite of grossly inadequate financing and staffing and especially to the plight of those American communities that have no local health service whatsoever.

I should like to emphasize that local health service means just that—health service to local areas—and is rendered either by a city, city-county, county, or multiple-county health department; or by State health districts established for the purpose of rendering direct service to local areas—and by "full-time health services," I mean those provided by a health unit under the direction of a full-time physician. As of June 30, 1948, almost half of the 3,069 counties in the United States had no full-time local health service. The counties without such service have an approximate population of 40,000,000 people.

Many of the 40,000,000 people who have no full-time local health service have come to the realization that their community is lacking an important service, but the local tax structure and the many demands made upon available resources have made it impossible for many local areas to support a public-health program without financial assistance.

Health units in the 1,668 counties reported as having some full-time local health service are in many instances so grossly understaffed that they are in fact but skeletal organizations. I need not tell the members of this committee that here again the inability of local resources to support competent public-health personnel in sufficient numbers reflects itself in inadequate public-health programs.

Ability to support a reasonably adequate public-health program has a significant effect on the distribution of public-health workers. We have repeatedly observed that given two comparable areas offering similar salaries, public-health personnel will tend to seek employment in the local health unit that is able to support a reasonably well staffed department rather than go to a department with such a limited budget that it must necessarily have a limited staff and, therefore, a limited program.

I should like to show you by means of a few charts the current situation with reference to the availability of local health services throughout the United States.

Chart 1 shows all areas reporting full-time local health service. The solid red color means that the areas are served by full-time local health departments, and the checkered areas are served by State health districts which report that they are rendering direct local health service.

As we look at this material more closely, we might find it of interest to relate the adequacy of health department staffing to the same areas as pictured in chart 1.

The next chart here will show the standards by which we judge the adequacy of local health services.

Although the staff requirements of an individual health department may vary with the community's local health needs and the scope of service the community desires, we are able, for the Nation as a whole, to look to the American Public Health Association for some minimum staffing standards.

From chart 2 we see that one public-health physician should be provided for 50,000 people; one public-health nurse for each 5,000; one sanitarian or sanitary engineer for each 25,000 persons; and one clerk for each 15,000.

Now, when we apply those standards to local health units, we see from chart 3, the areas that had enough public-health physicians on the job as of June 30, 1947, to meet the minimum staffing standards for public-health physicians. During 1948 more than one-fourth (27.6 percent) of the total health organizations serving nearly 35 percent (34.7 percent) of the counties had health officer vacancies.

Chart 4 gives similar information as far as public health nurses are concerned. I invite your attention to how relatively few areas have sufficient public-health nurses to meet minimum staffing standards. Some of this reflects scarcity of personnel, but a good deal of it stems from the fact that trained public-health nurses are leaving the field for better-paying positions.

Chart 5 shows the adequacy of staffing as far as sanitary engineering and sanitation personnel are concerned. A number of public-health engineers and sanitarians who served in the armed forces during World War II did not return to their former positions in local health departments because of the low salaries offered.

We have not presented a chart covering clerical staffing, for inadequacies in the numbers of such personnel are in many instances related to the understaffing of professional personnel.

Chart 6 reveals how few local health departments have enough of all four types of public health personnel—physician, nurse, public-health engineer or sanitarian, and clerk—to meet the minimum staffing standards for all four classes of personnel. Only 67 counties and 21 cities had local health service with a minimum-standard staff in all four classes of personnel.

The provision and administration of local health service is fundamentally a responsibility of local government. State legislative bodies have, to varying degrees, recognized that local areas cannot by themselves support adequate public-health programs, and a number of them have provided certain amounts to be made available for local health services.

The total funds available during fiscal year 1949 to State health departments, from State appropriating bodies, for all public-health purposes exclusive of those for the maintenance of hospitals and sanitoria, vary from a low of 8.2 cents per person per year to a high of 145.9 cents. The median figure is 37 cents per person per year.

Programs administered by State health departments have quite naturally absorbed a large part of these funds appropriated by State legislatures. Some of these programs have afforded certain services to local areas. Because of variations in State accounting practice, expenditures by State health departments for local health services cannot be completely identified in the reports submitted to the Public Health Service.

Table 1 presents available information concerning State support for identifiable local health services. You will note that States are grouped according to the percent of State founds made available for identifiable local health service. Nine States identified no funds for this purpose and 28 States contributed less than 20 percent.

Table 2 gives similar information for the Federal grant-in-aid appropriation known as general health. You will note that during fiscal year 1948, 13 States made less than 20 percent of this grant available for identifiable local health services and that only 20 States made more than 40 percent available for this purpose.

Of the Federal grant-in-aid funds given to States and expended by them during fiscal 1948 for general health purposes, 34.9 percent were spent for local health service. Conversely, 65.1 percent were spent by State health departments for State-level programs.

The implication of these tables and figures is clear. Since the tax resources of local government are often inadequate to establish and maintain full-time local health services, the communities must look to the State and Federal Government for assistance. State and Federal funds are not now being provided in such amount or in such a manner as to furnish a firm foundation for local health services. The principal objectives of the bills before you is to authorize sufficient funds to stimulate and assist the development of full-time local health units throughout the country.

Legislative approach: I should like to turn now to a brief discussion of the legislative means for meeting the needs of local health services.

While the bills before you have the same primary objective, they represent two basically different approaches. H. R. 267, H. R. 785, and section 4 of H. R. 4918 would provide in law for a separate earmarked grant which could be used only for the purpose named in the statute, namely, to assist in the support of local health services. This approach is a familiar one, having provided the statutory basis for many of our Federal grant-in-aid programs: Venereal-disease control, tuberculosis control, hospital construction, heart-disease control, for example.

Let me summarize briefly the principal provisions of H. R. 267, which is representative of these similar bills. I might also note that it is virtually identical to a bill reported, with some amendments, by your committee last year.

H. R. 267 recognizes the responsibility of States for the development of local health services and their need for assistance in doing this by authorizing Federal grants to the States, which in turn would be required to distribute the funds to local health units participating in their respective State plans. Each State would be required to develop a State plan for ultimate coverage of all areas of the State by adequately staffed and equipped local health units, and to develop an equitable method of allocation of funds to local areas.

Local health units, to be eligible for participation in the State plan, would have to meet minimum standards as to population served and as to the number of full-time personnel of various types. Regulations establishing criteria for minimum populations to be served by participating local health units and the minimum number and types of full-time personnel which local public-health units in various areas should employ would be issued by the Surgeon General with the approval of the Administrator only after consultation with a conference of State and Territorial health authorities.

For the country as a whole, the Federal grant would approximate 33⅓ percent of the expenditures of the participating local health units; but State by State the percentage would vary inversely with the State's average per capita income as compared with that of the United States. The States with the lowest income would receive the highest percentage but not to exceed 66⅔ percent of expenditures under the plan. The bill places a further limitation in specifying that expenditures in excess of $1.50 per capita shall not be counted for purposes of Federal matching unless the Congress specifically authorizes a higher limitation.

While we are in complete accord with the basic objective of H. R. 267, we cannot endorse the proposal to achieve this objective by adding still another statutory category to our present pattern of grants-in-aid for State and local health services. As you may recall, the Public Health Service Act already provides for a number of such categorical grant programs, including those in the fields of venereal disease, tuberculosis, mental health, and heart disease.

I should like to make it clear, Mr. Chairman, that our objection to statutory grant-in-aid categories does not apply particularly or exclusively to the proposed broad category for local health services. Our objection, rather, is to the principle of statutory categories. Experience has demonstrated that such categorical grants add to the complexity and rigidity of programs which should be flexible enough to meet changing needs and circumstances.

It is for this reason that we prefer the alternate form of legislation represented by title V of H. R. 4312 and H. R. 4313. This approach, in our opinion, would permit the achievement of the objectives of H. R. 267 without its administrative disadvantages.

While title V would amend the Public Health Service Act by removing the present statutory earmarking of appropriations for State and local health programs, it would not obliterate all special programs or all earmarking of Federal grant funds. On the contrary, it clearly authorizes special atention, not only for local health units and for all existing statutory programs, but for others not yet established—should the need for the development of special services arise. The difference is that, under the provisions of title V, such earmarking would be derived from administrative regulations or from line-item appropriations by the Congress.

Title V provides that each State would receive, subject to the availability of funds in its allotment, a proportion of the expenditures under the State plan equal to its Federal percentage. The Federal percentage for a State whose per capita income is identical with that of the continental United States would be 50 percent. Wealthier States would receive proportionately less, but no less than 40 percent, and States with low per capita income would receive up to 75 percent. There is no restriction on the total amount of State and local money spent for public health that could be used for matching purposes.

Conclusion: In conclusion, I may say we are all agreed that more Federal aid is urgently needed. In our opinion, the basic proposal in these bills dealing with local health services is one of the most important presented to the Congress in recent years. The Public Health Service favors the approach of title V of H. R. 4312 and H. R. 4313 over that of H. R. 267 solely in the interest of greater flexibility in the adminstration of grants. But whichever approach the Congress decides is the more appropriate will be welcomed by the Public Health Service—and I am sure, by State and local health agencies also—as a major step toward our common goal of improving the Nation's health.

In the interests of clarifying the principal differences between these two groups of bills, I have purposely confined this analysis to their contrasting approaches to a common objective. Regardless of which approach your committee selects, however, there are several amendments which we should like to offer for your consideration.

If you should prefer the approach of title V, a number of amendments, largely technical in character, would be necessary if it were to be taken out of its present context in an omnibus health measure and reported as a separate bill. We should be glad to submit our suggestions for such amendments for your consideration.

Similarly, if your committee should prefer to take action on H. R. 267, we are prepared to suggest a number of amendments. Most of these amendments parallel those made by your committee in reporting out a similar measure last year. In addition, there are several others which we believe would be desirable to facilitate the administration of the program, particularly during its first few years of operation.

This statement has not been officially cleared by the Bureau of the Budget. However, that Bureau has previously indicated its general approval of the approach represented by title V of H. R. 4312 and H. R. 4313, and its disapproval of the approach embodied in H. R. 267 and related bills.

Thank you, Mr. Chairman.

Mr. Priest. Thank you very much, Doctor. We appreciate your statement.

As I understand it, the position of the Public Health Service largely is the same that the service takes toward the medical-research bills.

You prefer the flexibility provided in title V of the omnibus bill to a fixed categorical set-up such as is proposed in H. R. 267?

Dr. Dearing. Quite so, sir. The administrative analogy between the research and public-health grants-in-aid is very proper.

Mr. Priest. Doctor, as you suggested, this particular statement has not been cleared by the Bureau of the Budget, and I wonder if you could give us, for the record, an estimate of what annual appropriations might be deemed necessary, supposing that this authorization is approved.

Dr. Dearing. Well, sir, I think we can give rough figures from estimates which we have made. Under H. R. 267, the appropriations required with the current coverage of local health units which would meet a standard would amount to something near $30,000,000, and the top that would be reached under that bill when we had national coverage under the $1.50 ceiling per capita would amount to somewhere around $80,000,000 to $85,000,000.

Under title V, the matching is not mandatory. It is up to the Congress as to what proportion they match, but there is no ceiling, as a matter of law; and if they matched according to formulas provided in title V and matched immediately on the maximum basis authorized, and the full amount, it would amount somewhere upward of $170,000,000 or a little more. Is that not true, Dr. Graning?

Dr. GRANING. That is right, sir.

Mr. PRIEST. That would be under the formula in title V?

Dr. DEARING. Yes, sir, which does not provide mandatory matching. It is left to the discretion of the Appropriations Committees and the Congress in the appropriation bills.

Mr. PRIEST. Mr. Wilson, do you have any questions?

Mr. WILSON. Yes, Mr. Chairman.

I notice that, in the closing part of the statement here, that there is disapproval, so far as the Bureau of the Budget is concerned, in the approach by H. R. 267.

Dr. DEARING. Yes, sir.

Mr. WILSON. Could you tell me briefly why they chose to disapprove, so far as they are concerned?

Dr. DEARING. Well, sir, that is because of the fact 267 would establish still another category which would require a special appropriation for special funds, and does not have as much flexibility as if the authorization, is general to make grants for general purposes and to establish by administrative regulations such special categories as might be necessary. It fixes the thing in law, not for all time, but for a long time, and we recognize from experience that sometimes they are not as easy to change; not as easy to change as the developments in the health field, and so forth.

Mr. WILSON. Now, Mr. Chairman, I also notice here the doctor has stated that they prefer the approach under title V of the omnibus bill, even if that is to be extracted as a separate bill; but in either instance, whether it is approached through 267 or title V of the omnibus bill, they have some suggested amendments.

Might we have the benefit of their suggestions, if they are available?

Mr. PRIEST. I think we should be glad to have them. I believe last year, when we reported the bill, most of those were somewhat technical; but it might be well, at this point, if you would discuss, Doctor, some of the amendments you propose to these bills. Of course, I realize that, in the redrafting of title V, it would require a considerable amount of redrafting if it is taken out as a separate bill.

Dr. DEARING. Yes, sir. As a matter of fact, as regards title V, we have prepared a draft of what it would be if recast as a separate bill, and it is in that form that I have it rather than in the form of amendment, line by line, or section by section, to title V.

I will be glad to submit that for the record, sir.

Mr. PRIEST. We will be very happy to have it for the record if you will put it in.

(The proposed redraft of title V above referred to is as follows:)

A BILL To amend the provisions of the Public Health Service Act relating to grants to States for State and local health work, and for other purposes

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That it shall be the national policy to assist the several States for the purpose of developing, extending, and improving—

(a) basic State and local public-health organizations and the basic services provided thereby, in order that such services, together with all other services provided through such organizations, may be readily available in communities throughout each State;

(b) organized community programs for the prevention and control of disease, including programs for the prevention and control of mental illness, tuberculosis, venereal disease, cancer, heart disease, other chronic diseases, disorders associated with aging, dental disorders, nutritional-deficiency diseases, occupational and other diseases constituting special health problems, and programs for the improvement of sanitation and other environmental factors affecting health;

(c) training of personnel for State and local health work and more effective methods for extending health services throughout each State.

SEC. 2. (a) Section 315 of the Public Health Service Act is hereby repealed.

(b) Effective July 1, 1949, part B of title II of the Public Health Service Act is amended by repealing section 314 and inserting immediately following section 313 the following new sections:

"APPROPRIATION FOR GRANTS AND SERVICES TO STATES

"SEC. 314. (a) There is hereby authorized to be appropriated for each fiscal year such amount as may be necessary for the purpose of—

"(1) enabling the Surgeon General to assist the States and their political subdivisions, through grants, to develop and maintain adequate public-health services, including establishment of local public-health units necessary to make such services available throughout each State, the training of personnel for State and local health work, and the establishment of organized community programs for the prevention and control of disease; and

"(2) enabling the Surgeon General to provide demonstrations and to train personnel for State and local health work and to meet the cost of pay, allowances, and traveling expenses of commissioned personnel and other personnel of the Service detailed to assist States and their political subdivisions in carrying out the purposes of this subsection.

"(b) The amounts appropriated pursuant to subsection (a) of this section and determined to be available for allotment to States under section 315 shall be used for making payments to States which have submitted through the State health authority and have had approved by the Surgeon General plans for carrying out the purposes of subsection (a).

"ALLOTMENTS TO STATES

"SEC. 315. From the amounts appropriated pursuant to section 314 for each fiscal year, the Surgeon General, with the approval of the Administrator, shall determine the total sum which shall be available for allotment among the several States and shall, from time to time, in accordance with regulations and for specified periods, make allotments from such sum (including amounts allotted from such sum for any prior period in the same fiscal year and remaining unpaid to the States) to the several States on the basis of (1) population, (2) per capita income as determined pursuant to subsection (d) of section 317, and (3) special factors relevant to the extent of the health problem in each such State. Upon making such allotments the Surgeon General shall notify the Secretary of the Treasury of the amounts thereof.

"APPROVAL OF STATE PLANS

"SEC. 316. (a) For any fiscal year the Surgeon General may by regulation prescribe, subject to any limitations specified in the appropriation made pursuant to section 314, the percentages of the allotments to the several States which may be withheld unless the State plan includes provisions (in addition to those required for the maintenance of the basic State health organizations and services) which meet the requirements of regulations, prescribed by the Surgeon General in order to effectuate the purposes of section 314 (a), for any of the following:

"(1) the establishment, development, and maintenance of local public-health units and basic local health services;

"(2) the establishment, development, and maintenance of an organized community program for the prevention and control of tuberculosis, venereal disease, cancer, mental illness, heart disease, other chronic diseases and disorders associated with aging, or any other disease, or category of disease;

"(3) the improvement of sanitation and other environmental factors affecting health;

"(4) the extension of improved techniques and public understanding of health problems in specific fields designated by the Surgeon General, through demonstrations or other special projects, including training.

The percentages so reserved on account of the above items may be varied, in accordance with regulations, on the basis of the extent of the problem in the several States.

"(b) No State plan shall be approved unless it (1) provides such methods relating to the establishment and maintenance of personnel standards on a merit basis as the Surgeon General finds necessary to assure the proper and efficient administration of the plan (except that the Surgeon General shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), (2) provides that the State health authority will make such reports in such form and containing such information, as the Surgeon General may from time to time require, and comply with such provisions as the Surgeon General may from time to time find necessary to assure the correctness and verification of such reports, and (3) provides that determinations as to individuals to be furnished services under the plan shall be made on bases which do not discriminate between individuals on account of race, creed, color, or national origin, and which do not otherwise deny to any of them the equal protection of the laws.

"PAYMENTS TO STATES

"SEC. 317. (a) From the allotments available therefor under section 315 the Surgeon General shall from time to time certify to the Secretary of the Treasury for payment to each State which has an approved plan an amount, computed as provided in subsection (b) of this section, equal to the Federal share of the total expenditures under such plan by the State and its political subdivisions during the period for which such payment is to be made, except that in no case may the total amount certified for a fiscal year for a State exceed the amount of its allotment less any portion thereof withheld pursuant to subsection (a) of section 316. No expenditure from grants received from the Federal Government under any provision of law (other than pursuant to this section) and no expenditures made by political subdivisions from funds which have been received by it from the State and which have been reported as expenditures by the State shall be counted as a part of the total expenditures under the plan. The Secretary of the Treasury shall, prior to audit or settlement by the General Accounting Office, pay to each State the amount certified by the Surgeon General.

"(b) The Surgeon General shall, from time to time, but not less often than semiannually and prior to the period for which the payment is to be made under subsection (a), estimate the amount, within the balance of the allotment for each State, which may be necessary to pay the Federal share of the total expenditures for carrying out the approved State plan for such period. The Surgeon General shall certify to the Secretary of the Treasury the amount so determined, reduced or increased, as the case may be, by the amounts by which he finds that his estimates for any prior period were greater or less than the amounts which should have been paid to the State for such period.

"(c) For the purposes of this section the 'Federal share' for any State shall be 100 percent less the State percentage, and the State percentage shall be that percentage which bears the same ratio to 30 percent as the per capita income of such State bears to the per capita income of the continental United States, except that (1) the Federal share shall in no case be more than 75 percent or less than 40 percent, and (2) until the Administrator finds that per capita income data are regularly available for Alaska, Hawaii, Puerto Rico, or the Virgin Islands, as the case may be, the Federal share for Hawaii shall be 50 percent and for Alaska, Puerto Rico, and the Virgin Islands shall be 75 percent.

"(d) The 'per capita income' and the 'Federal share' for each State shall be promulgated by the Administrator between July 1 and August 31 of each even-numbered year, on the basis of the average of the per capita incomes of the States and of the continental United States (excluding Alaska) for the three most recent consecutive years for which satisfactory data are available from the Department of Commerce. Such promulgation shall be conclusive for each of the two fiscal years in the period beginning July 1 next succeeding such promulgation: *Provided*, That the Administrator shall make such promulgation as soon as possible after the enactment of this Act to be effective until July 1, 1951. Until such time as the Administrator finds that per capita income data are regularly available for Hawaii, Alaska, Puerto Rico, and the Virgin Islands, as the case may be, 'per capita income' for Hawaii shall be the same as that of the State which has the median per capita income in the continental United States (excluding Alaska) and 'per capita income' for Alaska, Puerto Rico, or the Virgin Islands shall be the same as that of the State in continental United States (excluding Alaska) whose per capita income is lowest.

"OPERATION OF STATE PLANS

"SEC. 318. Whenever the Surgeon General, after reasonable notice and opportunity for hearing to the State health authority, finds that there is a failure to comply substantially with—

"(1) the provisions of section 316 of this Act;
"(2) the approved State plan; or
"(3) the regulations of the Surgeon General;

the Surgeon General shall notify the State health authority that further payments will not be made to the State from appropriations under section 314 (or, in his discretion, that further payments will not be made to the State from such appropriations for activities in which there is such failure) until he is satisfied that there will no longer be any such failure. Until he is so satisfied, the Surgeon General shall make no further certification for payment to such State, or shall limit payment to activities in which there is no such failure.

"REGULATIONS

"SEC. 319. All regulations and amendments thereto with respect to grants to States under this part shall be made after consultation with a conference of the State health authorities (including the State mental health authorities). Insofar as practicable the Surgeon General shall obtain the agreement, prior to the issuance of any such regulations or amendments, of the State health authorities including the State mental health authorities."

SEC. 3. Any amounts appropriated for the fiscal year ending June 30, 1950, for any of the purposes included in section 314 of the Public Health Service Act, as amended by this Act, shall be available for carrying out such purposes in accordance with the provisions of such section, as so amended: *Provided*, That the Surgeon General may designate the extent to which regulations promulgated pursuant to section 314 of the Public Health Service Act, prior to its amendment by this Act, shall govern allotments and payments to States for such fiscal year.

SEC. 4. Section 313 of the Public Health Service Act is hereby amended to read as follows:

"PUBLIC EDUCATION, INFORMATION, AND VITAL STATISTICS

"SEC. 313. (a) From time to time the Surgeon General shall issue information related to public health, in the form of publications or otherwise, for the use of the public, and shall publish weekly reports of health conditions in the United States and other countries and other pertinent health information for the use of persons and institutions engaged in work related to the functions of the Service.

"(b) To secure uniformity in the registration of mortality, morbidity, and vital statistics the Surgeon General shall prepare and distribute suitable and necessary forms for the collection and compilation of such statistics which shall be published as a part of the health reports published by the Surgeon General."

Dr. DEARING. Now, with regard to changes in 267, some of them would simply correct dates, and things of that sort, and make it apply to this year instead of last.

Mr. WILSON. Those are just clarifying amendments?

Dr. DEARING. Yes, sir.

Mr. PRIEST. But there were one or two other amendments that were adopted by the committee last year at the suggestion, I believe, of the Surgeon General.

Dr. DEARING. Yes, sir.

Mr. PRIEST. Do you have those, Doctor?

Dr. DEARING. Yes; we have those, and we also have a few additional matters which have come to mind and which we think would be helpful.

The amendments that I have and the form they are in are in the committee print as reported last year, which was easier to work from. The substance of it would be to add to what would be the new section 15 of the Public Health Service Act an authorization to extend the time and to add some flexibility by regulations. Health departments might have difficulty initially in meeting the criteria which eventually they would be expected to meet.

The bill as originally drafted authorized the establishment of criteria by regulation and no community or no department could get grants unless they met those criteria; but in order to provide an opportunity to get some help, if they were coming up to snuff, this would authorize the establishment of some flexibility in that regard.

Mr. PRIEST. That flexibility might enable such local communities eventually to meet the criteria requirements.

Dr. DEARING. Yes, sir. As a matter of fact, there are two places where that type of language should be put in, and then there are other amendments. We propose to make clear and definite that the expenditures in each individual community must be considered separately for the purpose of matching rather than that a community which is away over the per capita could have its funds counted for matching in other areas. That would maintain the principle of local support.

Then, there is a proposed protection of a State against sudden changing of regulations which are authorized, so that the State would have, I believe, 2 years to conform to the new regulations; would not be required to change its State plan overnight, even though the Surgeon General, on recommendation of the State and Territorial health officers, changed the regulation, which would apply easily to a majority of the States.

Mr. PRIEST. Aside from the fact, Doctor, that the department is opposed, from the standpoint of policy, to establishing new categories, is it not your opinion that otherwise the bill as reported by the committee last year, with the amendments adopted by the committee, was a rather satisfactory bill?

Dr. DEARING. Yes, sir. It would do the job and would really result in a real advance.

Mr. PRIEST. Mr. Wilson?

Mr. WILSON. Mr. Chairman, as I understand the real basic objection of the Bureau of the Budget is establishing another category.

Mr. PRIEST. The same objection, I think, Mr. Wilson, that comes as a result of our consideration of the medical research institute rather than establishing individual researches. In other words, it is a fundamental policy rather than establishing an institute on multiple sclerosis, arthritis, and rheumatism, or a large number of these various institutes, they prefer the flexibility of a general grant-in-aid program without tying it down too tightly by legislative enactment.

I think, as I understand it, that is primarily the objection; is that correct, Doctor?

Dr. Dearing. Yes, sir. Mr. Chairman, Dr. Mountin also reminds me that the Bureau of the Budget also expressed reservations about a mandatory appropriation feature of H. R. 267. That is another point which I neglected to mention in connection with this, as well as the objection to additional categories.

Mr. Priest. Mr. Bennett.

Mr. Bennett. Doctor, how are these funds matched under present law between State and Federal? Is that an arbitrary arrangement or is it a flexible one?

Dr. Dearing. It is somewhat flexible. I will ask Dr. Mountin to discuss it in detail. I would say only there is no stautory matching required under the present authorization. What we do in the various appropriations I will ask Dr. Mountin to describe to you.

Dr. Mountin. The amount is established by regulation. It is not set up in the act.

Mr. Bennett. Well, under present law, can you pay for the whole program of a particular State or locality?

Dr. Mountin. I am sorry, but I did not get your question.

Mr. Bennett. Under present law, can your department allocate whatever sums of money it wants to a particular State. irrespective of the amount the State contributes?

Dr. Mountin. The act requires that the money be allocated to the States in accordance with a formula which takes into account three criteria: population, financial need, and the extent of the problem. That is prescribed in the law. The weighting of the different factors, however, is subject to regulation.

Now, so far as the matching is concerned, that is, the amount that the State and locality must put up, the amount is determined by regulation. That is not prescribed under the present laws under which we are operating.

Mr. Bennett. You could, under the present law, you could pay 90 percent and require the State to put up only 10 percent?

Dr. Mountin. Theoretically, yes; but practically, the States do much better than the Federal Government. There is no matching of less than 50 percent of the Federal expenditures.

Dr. Dearing. The real practical limitation is the amount of the appropriation.

Dr. Mountin. Yes.

Dr. Dearing. If we paid 90 percent to one State, there would not be enough left for more than a few other States, and around 50 percent is the maximum we have required.

Dr. Mountin. These regulations, I might add, are subject to approval by the Administrator, and they are developed, in the first place, after conference with State and Territorial health officers.

Dr. Dearing. That consultation is required in the law.

Dr. Mountin. That is required in the law; yes, sir.

Mr. Bennett. Well, do you want the present arrangement continued? Is title V, for example, of the omnibus bill written in such a way that it will carry out the plan as it is in the present law?

Dr. Dearing. No, sir; it would prescribe a matching formula which would set a lower limit of 40 percent and an upper limit of 75 percent; matching to correspond inversely with the per capita income.

Mr. Bennett. Is that somewhat on the same basis as your hospital program; hospital construction program?

Dr. Dearing. Somewhat; but it is much simpler and does not involve this allotment percentage which we discussed the other day. It is simply an inverse ratio of the per capita to the population.

Mr. Bennett. Do you not, under title V, for example, of H. R. 4312, require that each State be allotted a certain amount of Federal funds under a State plan, showing to what purpose it is proposed to be applied?

Dr. Dearing. Yes, sir; to be eligible a State must submit a plan, and that plan must meet certain criteria set forth in the statute, including—and this is new—they must present a plan for developing complete coverage of the State. At the moment, there is no such requirement in law and the State could get help for one health unit or not or could have all its funds at the State level.

This would require that in that plan they provide for local health services and a State-wide plan for extension of local health services, before they could even start, and that type of criteria is set forth in the regulation which the State plan must meet.

Mr. Bennett. Well, the criteria—is that not the same as under the hospitalization program, so far as allotment to the State is concerned?

Dr. Dearing. Correct.

Mr. Bennett. The State, first of all, has to submit a plan?

Dr. Dearing. Yes, sir.

Mr. Bennett. For their local health units?

Dr. Dearing. Yes, sir.

Mr. Bennett. And the amount of percentage of the funds that are allotted to them is based on your approval of that plan?

Dr. Dearing. Well, the proportion of matching is based on the approval, according to the formula set forth in the statute, based on per capita income, but the amount of money which they get depends on how many participating local health units they have and how much money goes into them up to $1.50 per capita.

I understood you asked what it would be under the plan, sir. Are you asking what the present practice is?

Mr. Bennett. I am asking how it would work under title V?

No State can be allowed more than $1.50 per capita under title V in any event?

Dr. Dearing. Well, $1.50 is the maximum amount of the State funds. That can be matched up to 65 percent. The Federal Government could put in—the State maximum allotment—or rather, minimum matching requirement, which would be 25 percent. Your $1.50 would count as 25 percent and then the State, and the Federal Government could put in 75 percent over that. Is that not correct?

Mr. Bennett. This may be clear to some members of the committee, but it is not very clear to me. Can you take a specific State, or a hypothetical case: How, in a concrete way, would it work out? First of all, so far as the Federal funds as against State funds are concerned, and secondly, as to the requirement of the title, so far as percentage distribution is concerned between the States. That is not clear to me at all.

Dr. Dearing. There is no formula which would in advance set up a certain amount of money for each State, as there is for the Hospital Construction Act. In the latter it is determined in advance by formula. There is no such provision here, as to the amount of money to go to each State.

Mr. Priest. Will you excuse an interruption?

Mr. Bennett. Yes.

Mr. Priest. Why should there not be?

Dr. Dearing. Well, the needs and the ability to use the funds vary substantially and there is not the situation here that there is in construction whereby we are meeting, even with the amendments now under consideration before the committee, only 20 percent of the construction needs as demonstrated by the States themselves. That is something you can put down very definitely and there is a development which requires the hiring of people and it is a thing which you cannot nail down in costs as well as you can bricks and mortar.

Mr. Wilson. Dr. Dearing, the charts on display at the moment before the committee show just what you are talking about, I believe. I think that some 20 States spent 40 percent or more of their general health funds for local health services.

Dr. Dearing. Yes, sir.

Mr. Wilson. I believe that is illustrative of what is being talked about.

Dr. Dearing. H. R. 267 is designed not only to give more adequate support but to insure or require that the support go to the development of local services and that the local communities take some responsibility.

Now, whether the funds for each local community come from the State or the local community is not important, but the money must be spent there to get Federal matching funds.

Mr. Bennett. Under the present law, can you allocate money to a locality?

Dr. Dearing. No, sir; only through the States.

Mr. Bennett. Does your agency lay down the standards by which professional staffs are hired; that is, what educational requirements public health nurses must have?

Dr. Dearing. Our laws require that the State operate under the merit system; but also prohibits any Federal interference or regulations regarding who may be hired.

Mr. Bennett. Puts it under Federal civil service?

Dr. Dearing. It requires that the State operate under the merit system.

Mr. Bennett. What do you mean by that; a civil-service system?

Dr. Dearing. A State civil-service system; yes, sir.

Mr. Bennett. That is all.

Mr. Priest. Mr. Gillette.

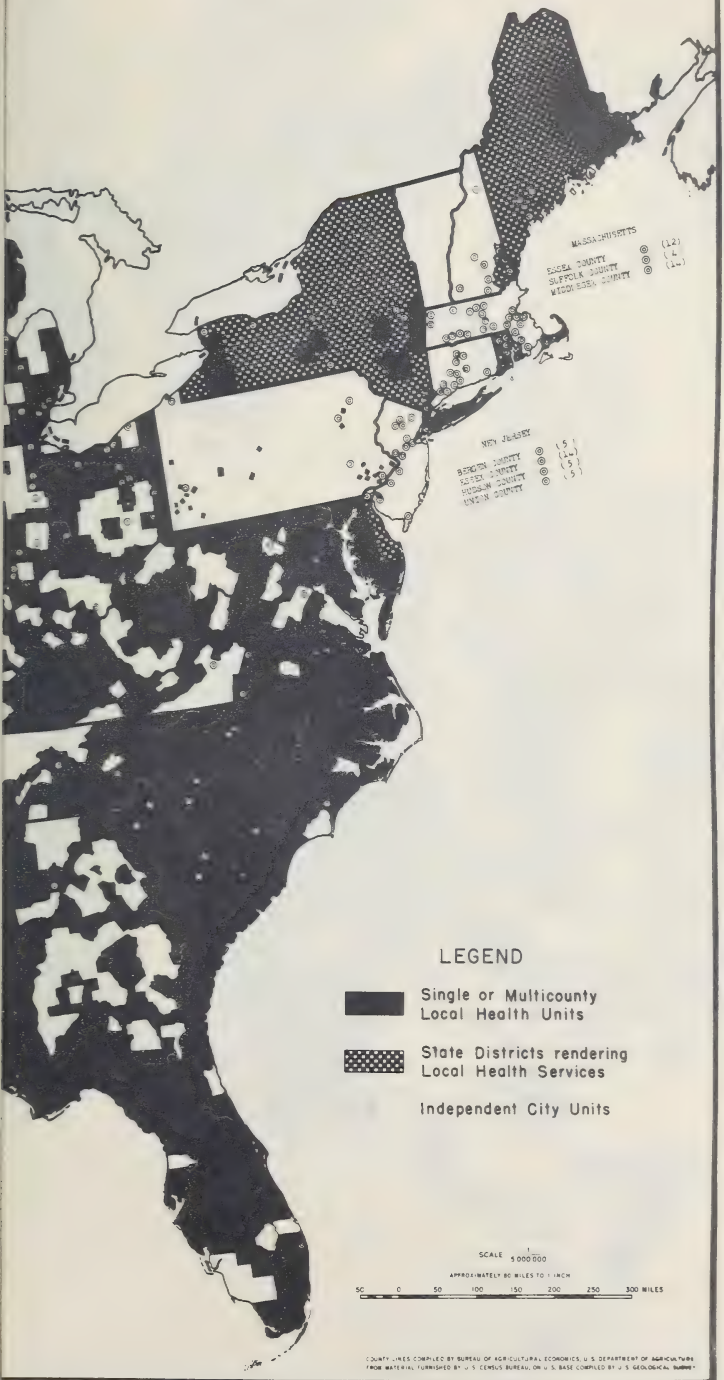
Mr. Gillette. Did I understand you, Doctor, that there is a ceiling put on in the amount of money that a State can put in and not the Federal Government?

Dr. Dearing. Well, sir, it differs in the two bills. H. R. 267 would require a ceiling, would establish a ceiling of $1.50. Title V would not. In the latter the ceiling or the amount that the Federal Government would put up would be determined annually by appropriations. That is wherein, Mr. Bennett, I was incorrect, when you asked me about title V. I discussed H. R. 267 instead.

Mr. Priest. Will the gentleman from Pennsylvania yield?

Mr. Gillette. Certainly.

VICES - JUNE 1948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SUFFOLK COUNTY ◎ (4)
MIDDLESEX COUNTY ◎ (14)
NEW JERSEY
BERGEN COUNTY ◎ (5)
ESSEX COUNTY ◎ (14)
HUDSON COUNTY ◎ (5)
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▨ State Districts rendering Local Health Services
Independent City Units
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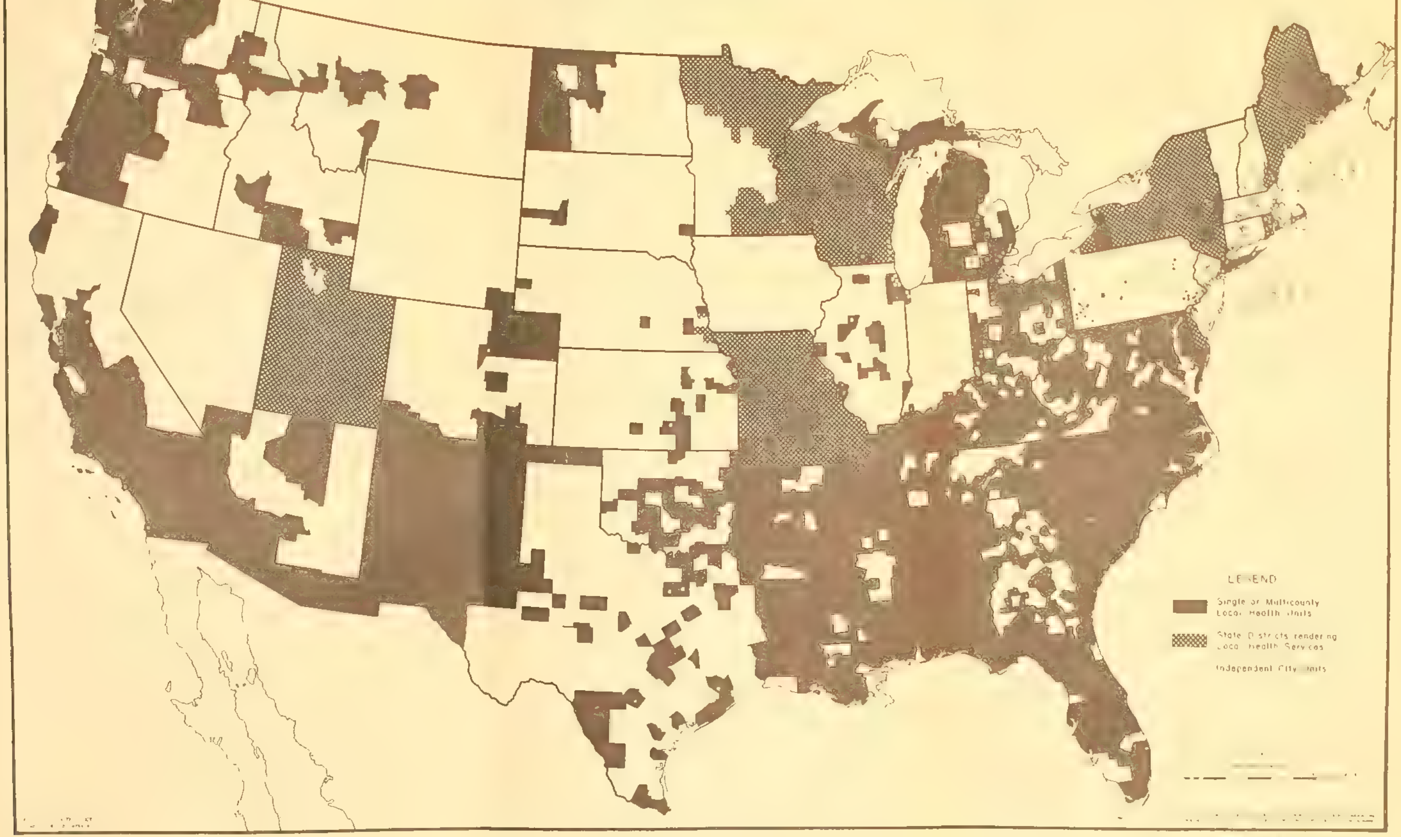
COUNTY LINES COMPILED BY BUREAU OF AGRICULTURAL ECONOMICS, U. S. DEPARTMENT OF AGRICULTURE FROM MATERIAL FURNISHED BY U. S. CENSUS BUREAU, ON U. S. BASE COMPILED BY U. S. GEOLOGICAL SURVEY

AREAS REPORTING FULL-TIME LOCAL HEALTH SERVICES - JUNE 1948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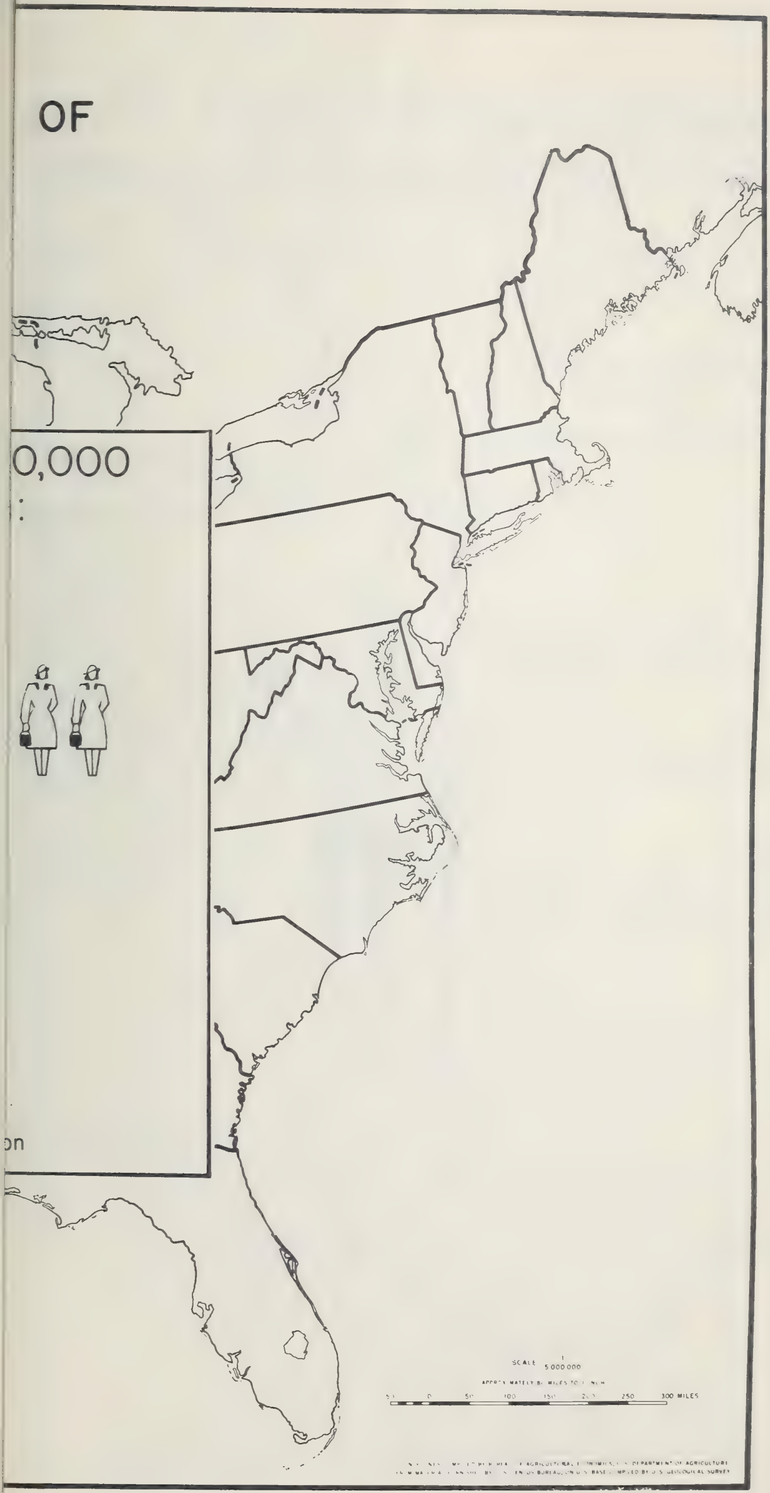
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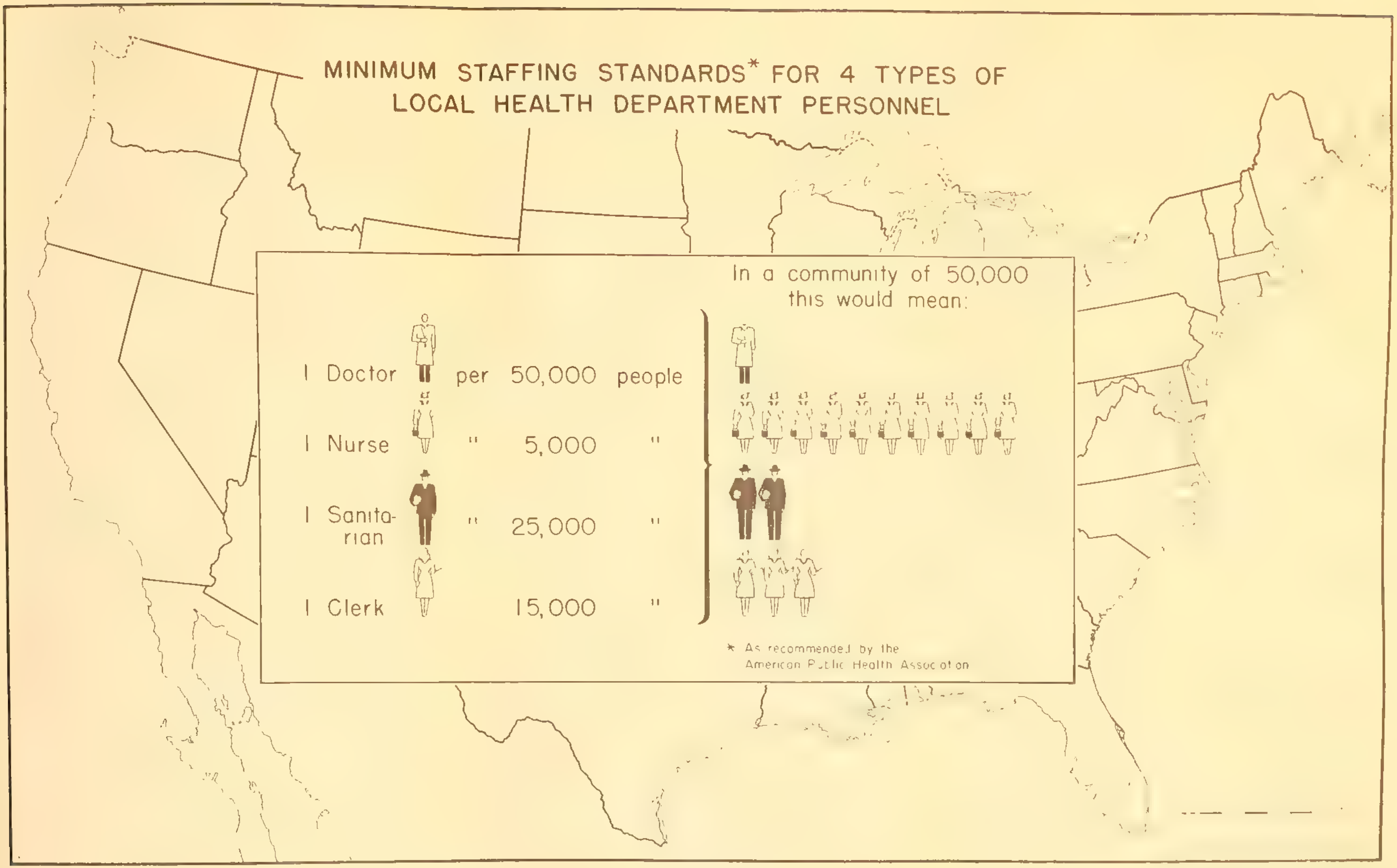
MINIMUM STAFFING STANDARDS* FOR 4 TYPES OF LOCAL HEALTH DEPARTMENT PERSONNEL



* As recommended by the American Public Health Association

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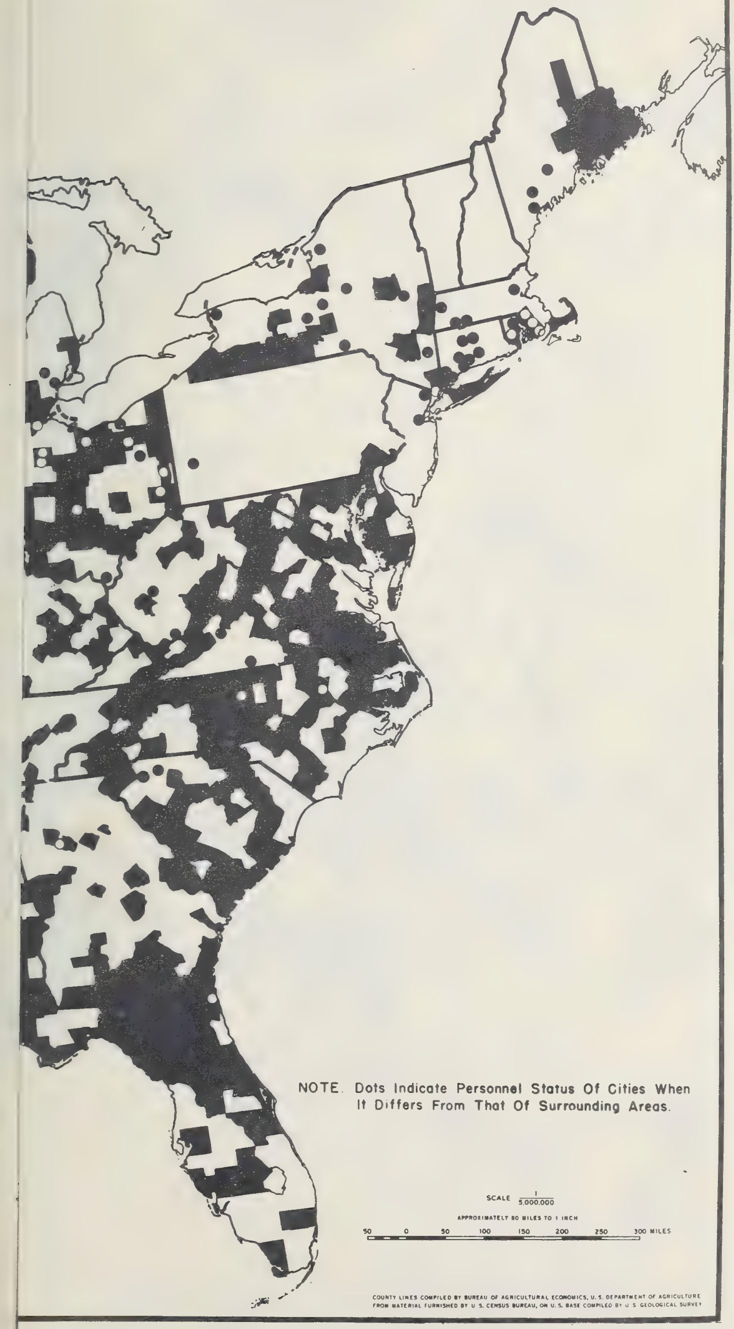
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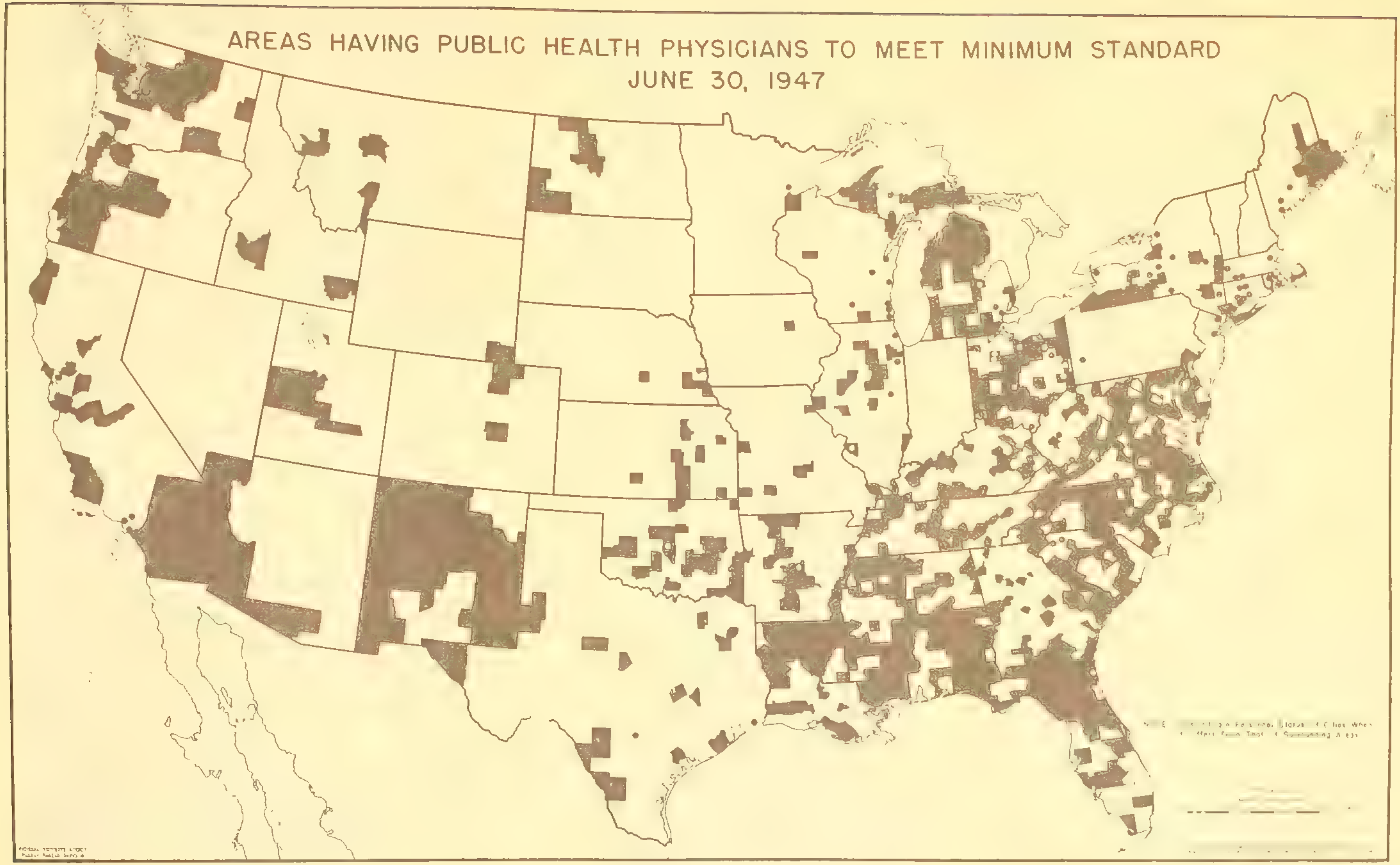
NOTE. Dots Indicate Personnel Status Of Cities When It Differs From That Of Surrounding Areas.

COUNTY LINES COMPILED BY BUREAU OF AGRICULTURAL ECONOMICS, U. S. DEPARTMENT OF AGRICULTURE FROM MATERIAL FURNISHED BY U. S. CENSUS BUREAU, ON U. S. BASE COMPILED BY U. S. GEOLOGICAL SURVEY

93612 O - 49 (Face p. 940) No. 3

AREAS HAVING PUBLIC HEALTH PHYSICIANS TO MEET MINIMUM STANDARD
JUNE 30, 1947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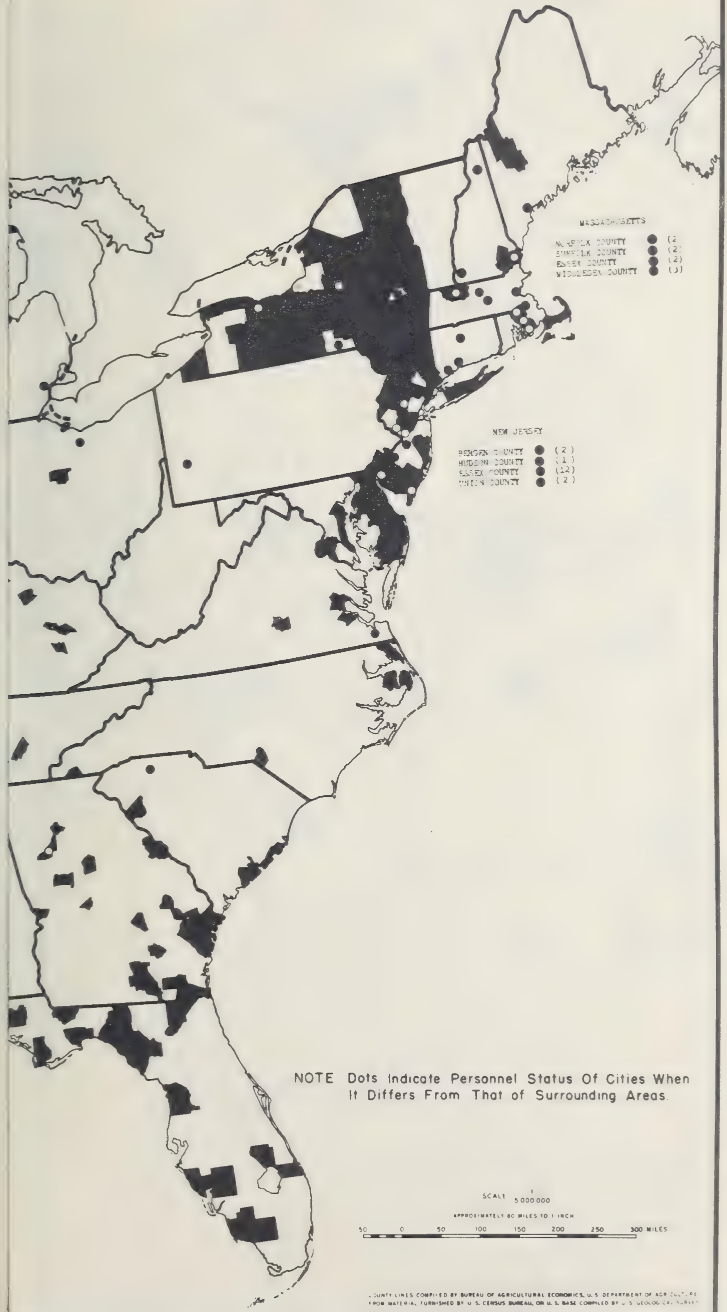
FEDERAL SECURITY AGENCY
Public Health Service

IMUM STANDARD


MASSACHUSETTS
NORFOLK COUNTY ● (2
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ESSEX COUNTY ● (2)
MIDDLESEX COUNTY ● (3)
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BERGEN COUNTY ● (2)
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ESSEX COUNTY ● (12)
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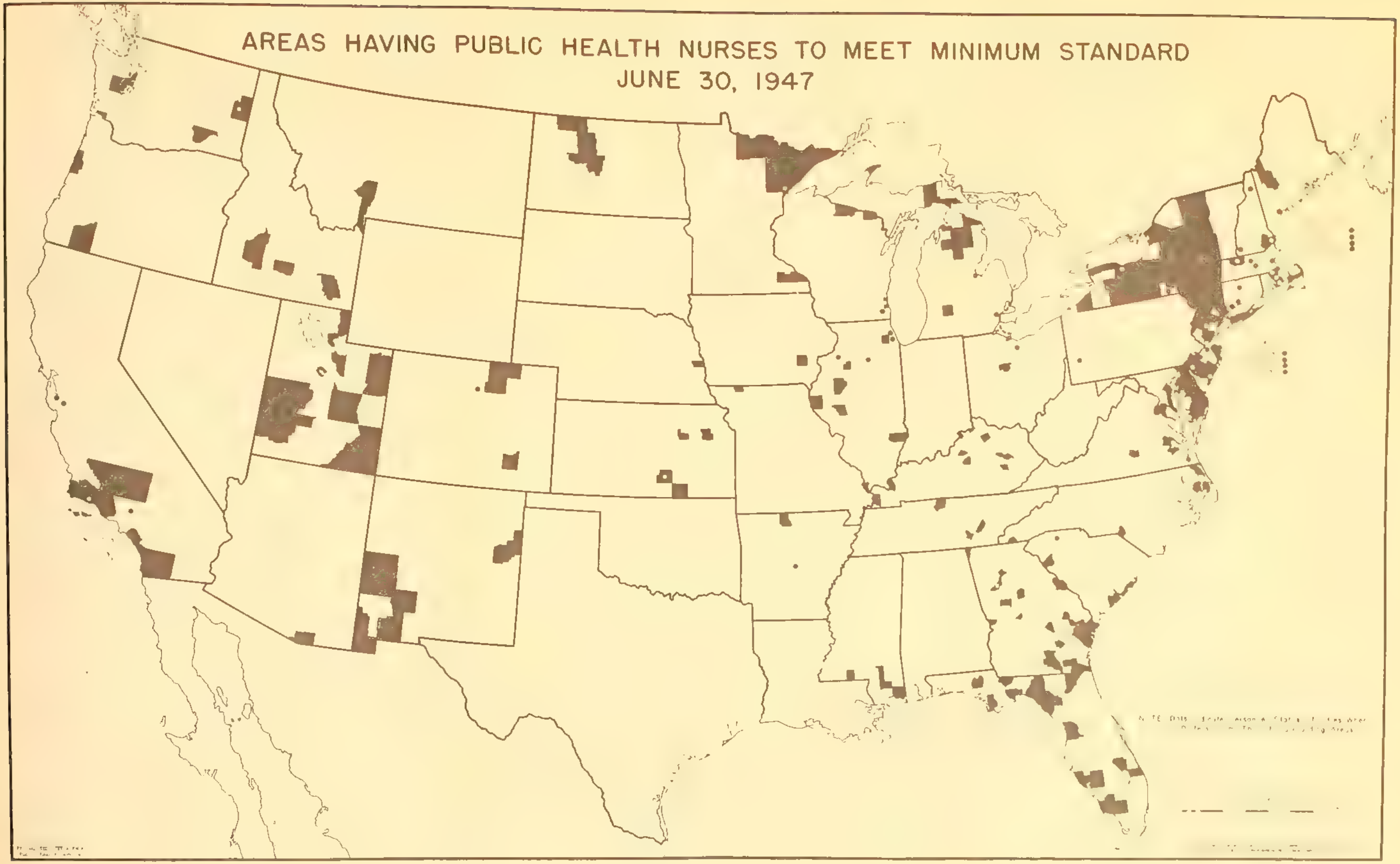
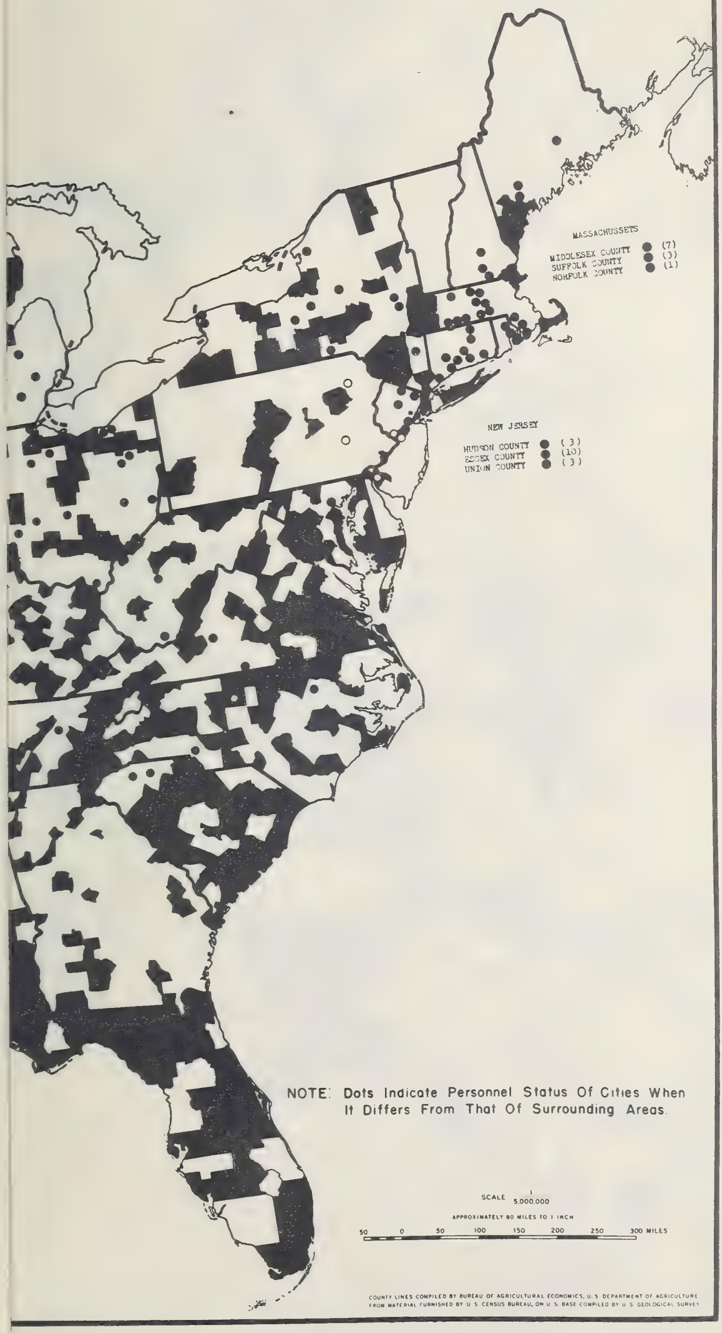
NOTE Dots Indicate Personnel Status Of Cities When It Differs From That of Surrounding Areas.

COUNTY LINES COMPILED BY BUREAU OF AGRICULTURAL ECONOMICS, U. S. DEPARTMENT OF AGRICULTURE FROM MATERIAL FURNISHED BY U. S. CENSUS BUREAU, ON U. S. BASE COMPILED BY U. S. GEOLOGICAL SURVEY



AREAS HAVING PUBLIC HEALTH NURSES TO MEET MINIMUM STANDARD
JUNE 30, 1947

MUM STANDARD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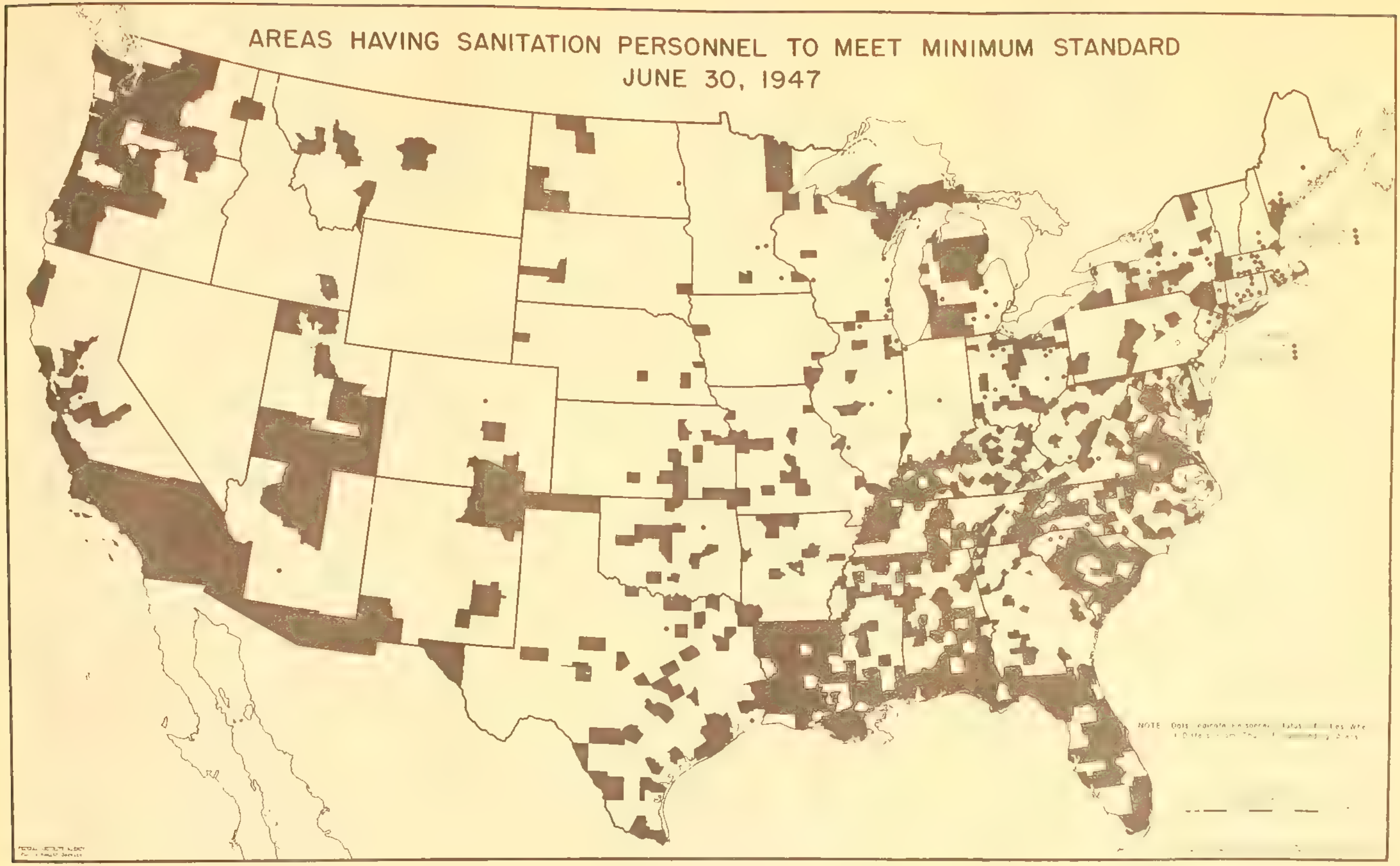
NOTE: Dots Indicate Personnel Status Of Cities When It Differs From That Of Surrounding Areas.

COUNTY LINES COMPILED BY BUREAU OF AGRICULTURAL ECONOMICS, U. S. DEPARTMENT OF AGRICULTURE FROM MATERIAL FURNISHED BY U. S. CENSUS BUREAU, ON U. S. BASE COMPILED BY U. S. GEOLOGICAL SURVEY

93612 O - 49 (Face p. 940) No. 5

AREAS HAVING SANITATION PERSONNEL TO MEET MINIMUM STANDARD
JUNE 30, 1947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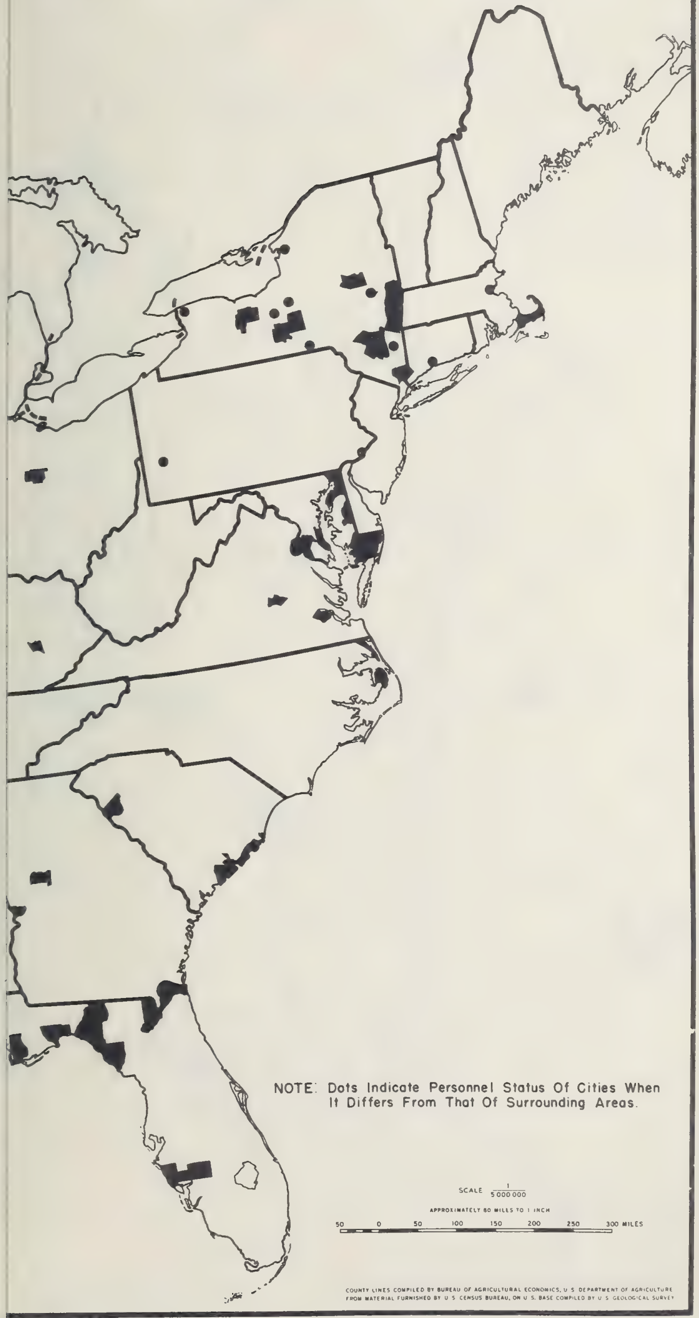
FEDERAL SECURITY AGENCY
Public Health Service

DEPARTMENT
30, 1947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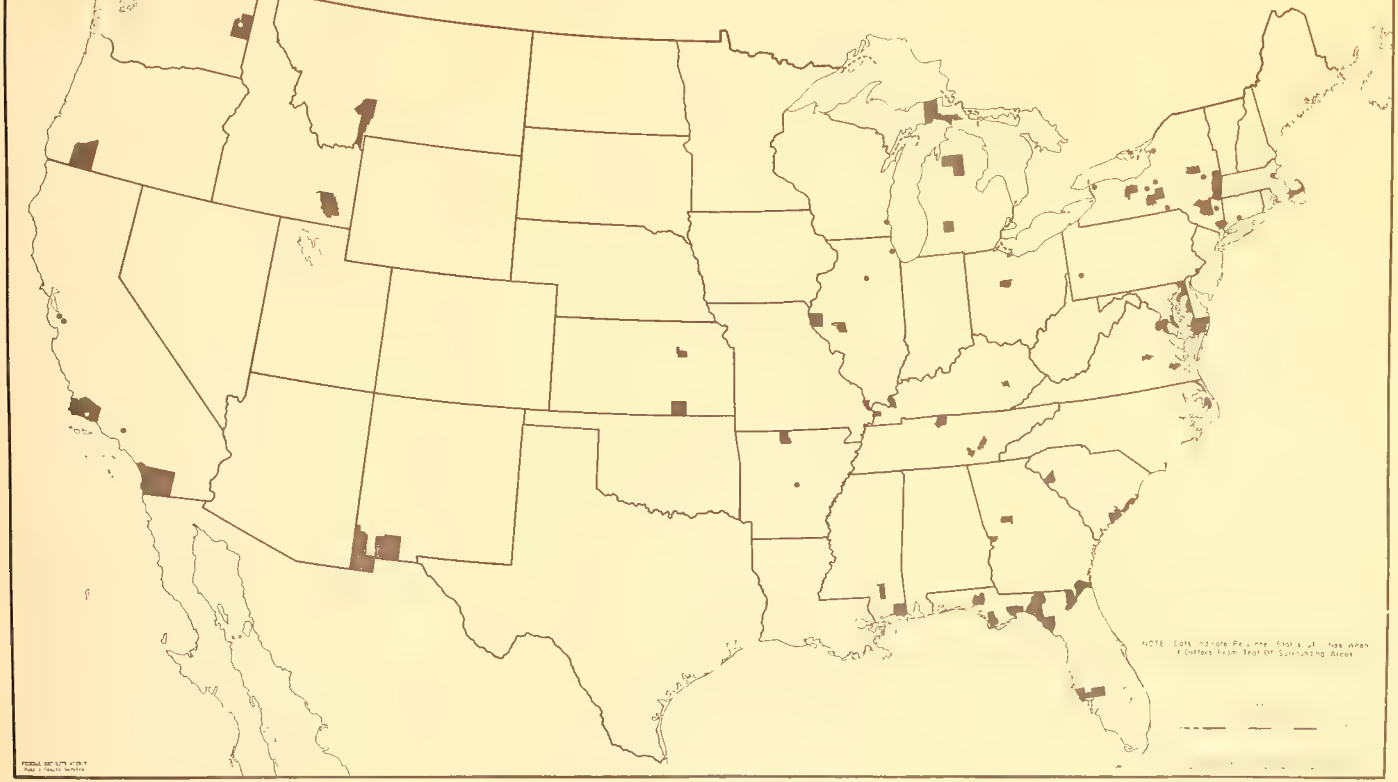
NOTE: Dots Indicate Personnel Status Of Cities When It Differs From That Of Surrounding Areas.

COUNTY LINES COMPILED BY BUREAU OF AGRICULTURAL ECONOMICS, U S DEPARTMENT OF AGRICULTURE FROM MATERIAL FURNISHED BY U S CENSUS BUREAU, ON U S. BASE COMPILED BY U S GEOLOGICAL SURVEY

AREAS HAVING ALL FOUR CLASSES OF BASIC HEALTH DEPARTMENT PERSONNEL TO MEET MINIMUM STANDARD – JUNE 30, 1947



NOTE: Dots Indicate Personnel Status of Cities When It Differs From That Of Surrounding Areas

FEDERAL SECURITY AGENCY
Public Health Service

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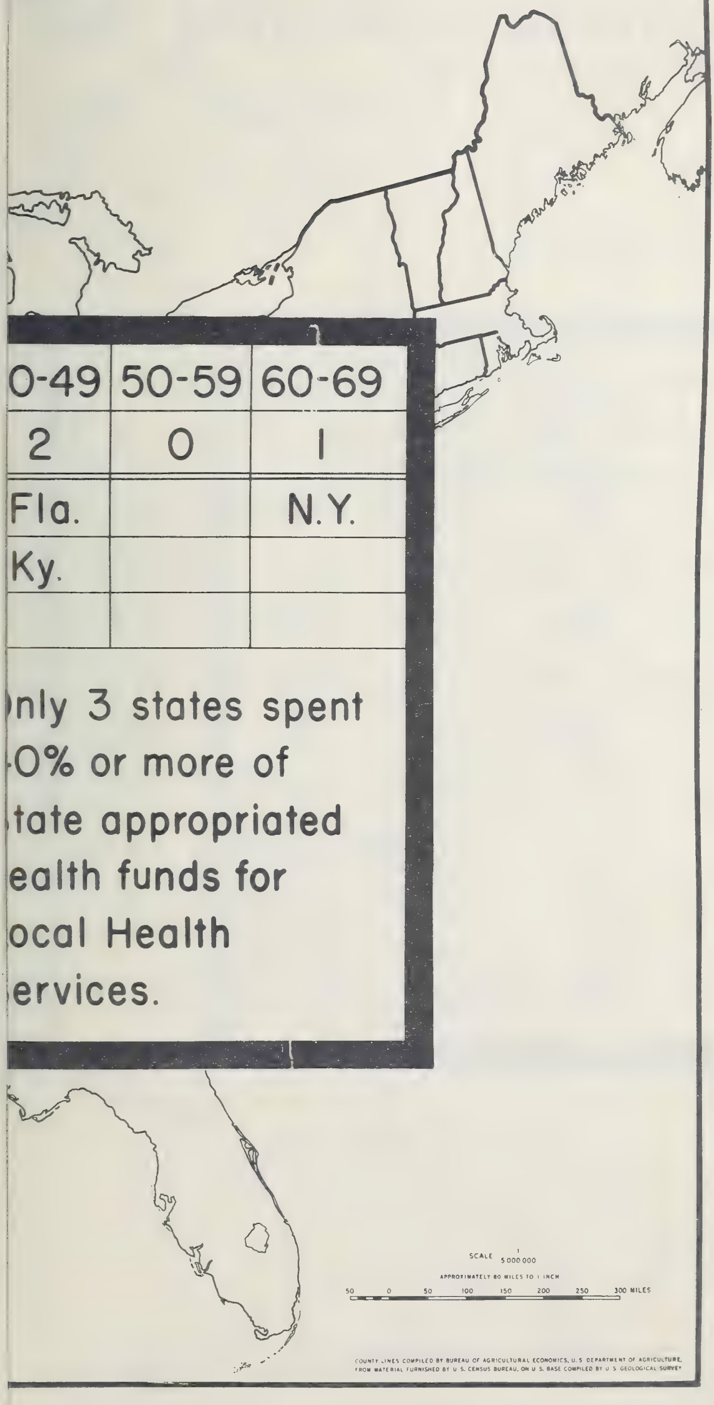

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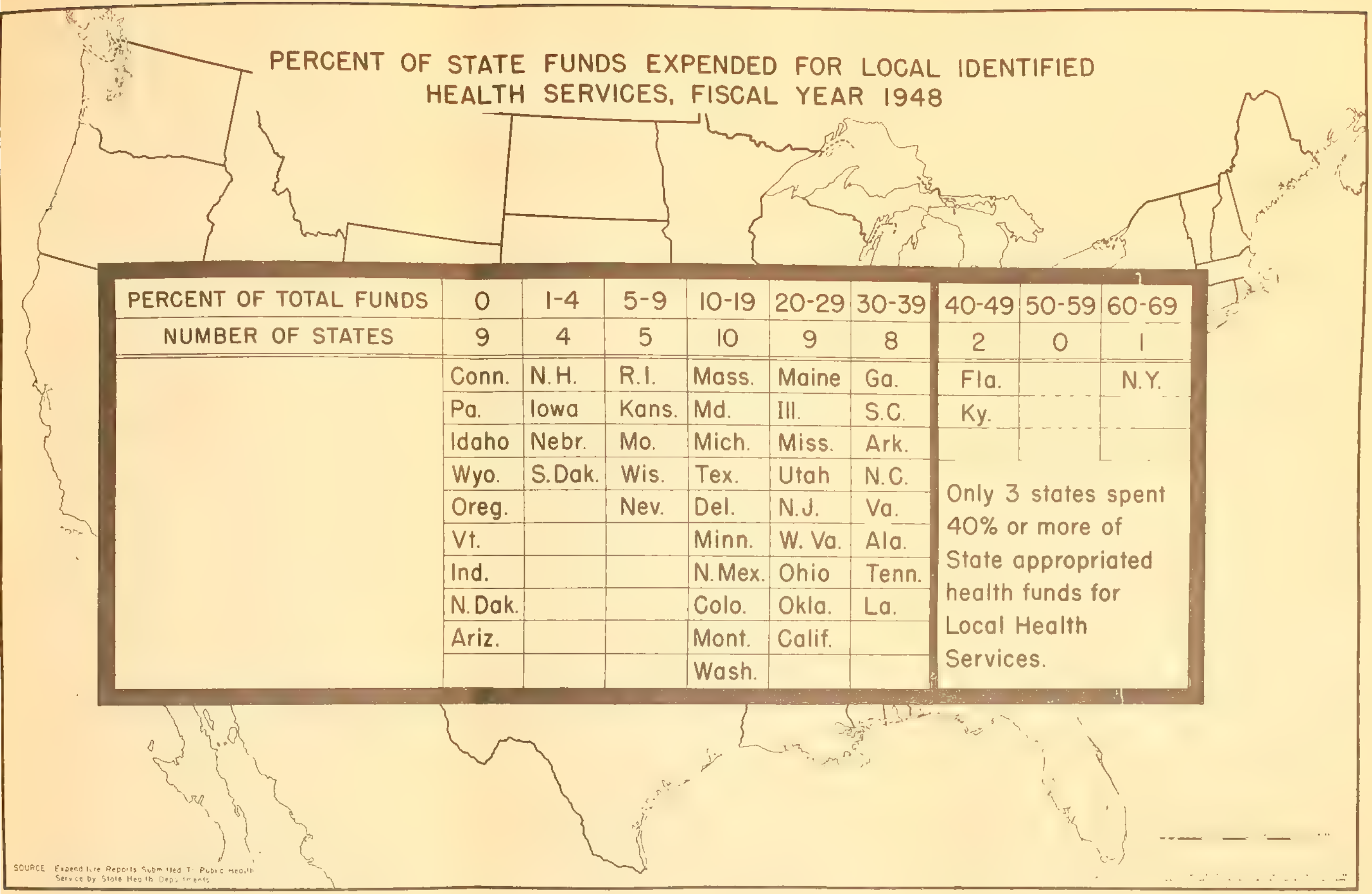
COUNTY LINES COMPILED BY BUREAU OF AGRICULTURAL ECONOMICS, U. S. DEPARTMENT OF AGRICULTURE, FROM MATERIAL FURNISHED BY U. S. CENSUS BUREAU, ON U. S. BASE COMPILED BY U. S. GEOLOGICAL SURVEY

PERCENT OF STATE FUNDS EXPENDED FOR LOCAL IDENTIFIED HEALTH SERVICES, FISCAL YEAR 1948

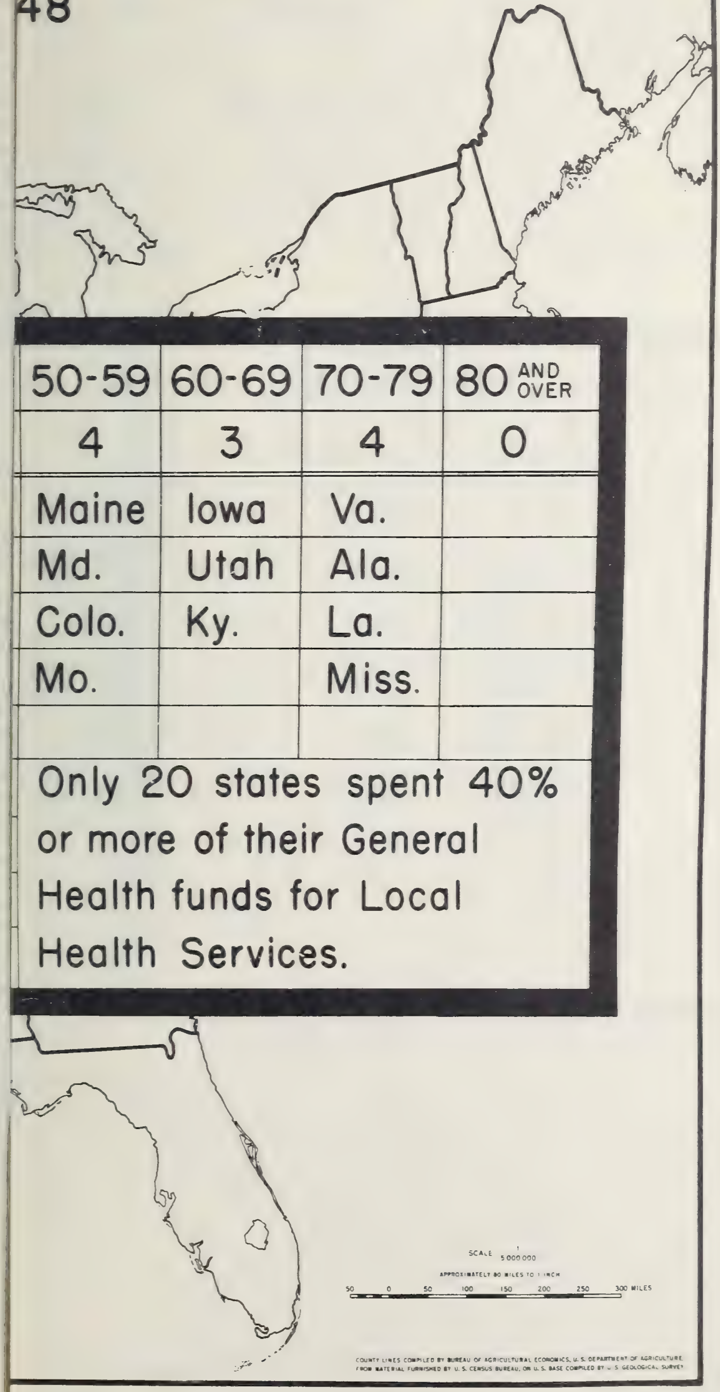


PERCENT OF TOTAL FUNDS	0	1-4	5-9	10-19	20-29	30-39	40-49	50-59	60-69
NUMBER OF STATES	9	4	5	10	9	8	2	0	1
	Conn.	N.H.	R.I.	Mass.	Maine	Ga.	Fla.		N.Y.
	Pa.	Iowa	Kans.	Md.	Ill.	S.C.	Ky.		
	Idaho	Nebr.	Mo.	Mich.	Miss.	Ark.			
	Wyo.	S.Dak.	Wis.	Tex.	Utah	N.C.			
	Oreg.		Nev.	Del.	N.J.	Va.			
	Vt.			Minn.	W. Va.	Ala.			
	Ind.			N.Mex.	Ohio	Tenn.			
	N.Dak.			Colo.	Okla.	La.			
	Ariz.			Mont.	Calif.				
				Wash.					

Only 3 states spent 40% or more of State appropriated health funds for Local Health Services.

SOURCE Expenditure Reports Submitted To Public Health Service by State Health Departments

FOR IDENTIFIED
48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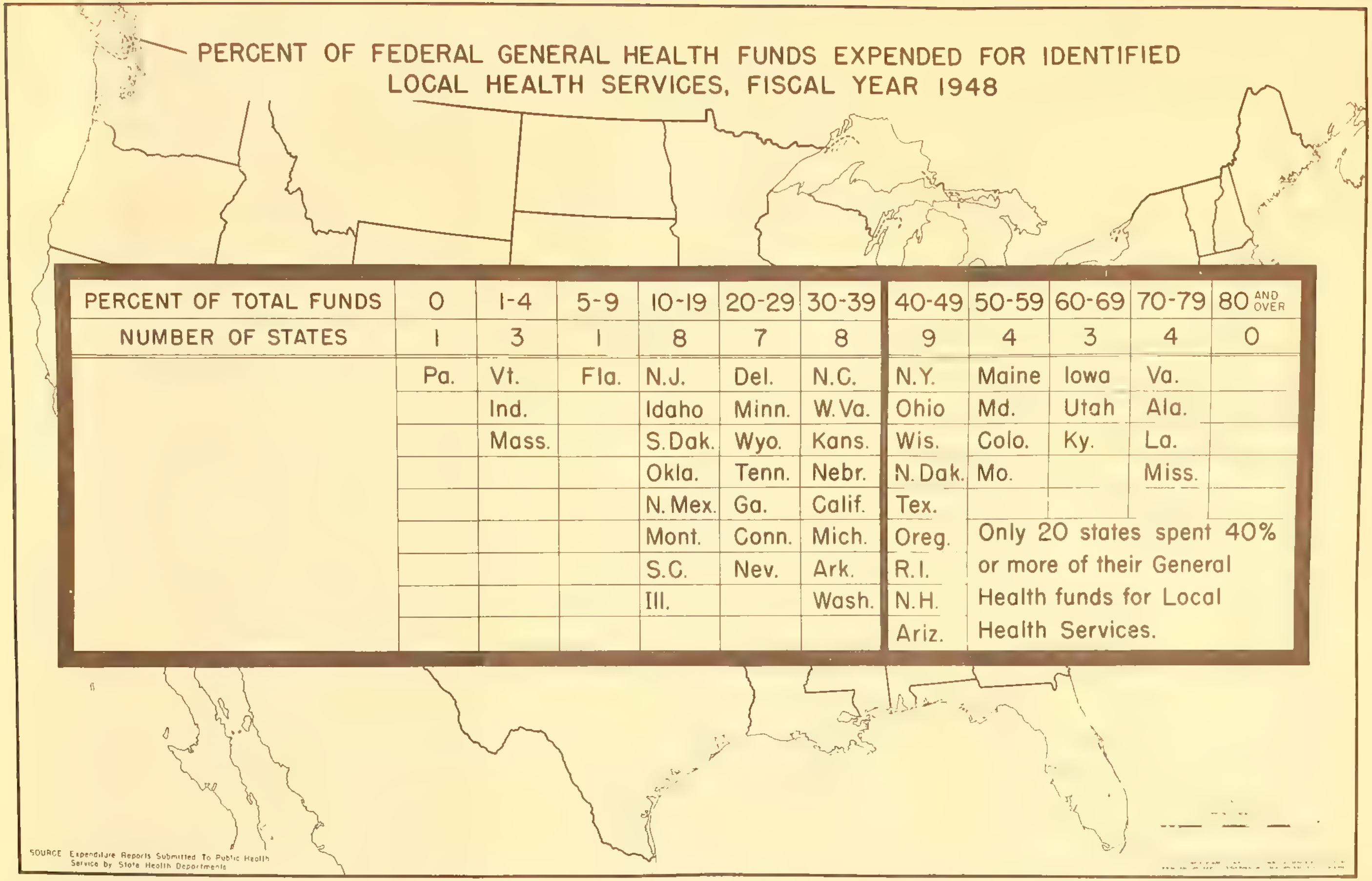
FROM MATERIAL FURNISHED BY U. S. CENSUS BUREAU, ON U. S. BASE COMPILED BY U. S. GEOLOGICAL SURVEY

50-59	60-69	70-79	80 AND OVER
4	3	4	0
Maine	Iowa	Va.	
Md.	Utah	Ala.	
Colo.	Ky.	La.	
Mo.		Miss.	

Only 20 states spent 40% or more of their General Health funds for Local Health Services.

93612 O - 49 (Face p. 940) No. 8



PERCENT OF FEDERAL GENERAL HEALTH FUNDS EXPENDED FOR IDENTIFIED LOCAL HEALTH SERVICES, FISCAL YEAR 1948

PERCENT OF TOTAL FUNDS	0	1-4	5-9	10-19	20-29	30-39	40-49	50-59	60-69	70-79	80 AND OVER
NUMBER OF STATES	1	3	1	8	7	8	9	4	3	4	0
	Pa.	Vt.	Fla.	N.J.	Del.	N.C.	N.Y.	Maine	Iowa	Va.	
		Ind.		Idaho	Minn.	W.Va.	Ohio	Md.	Utah	Ala.	
		Mass.		S.Dak.	Wyo.	Kans.	Wis.	Colo.	Ky.	La.	
				Okla.	Tenn.	Nebr.	N.Dak.	Mo.		Miss.	
				N.Mex.	Ga.	Calif.	Tex.				
				Mont.	Conn.	Mich.	Oreg.				
				S.C.	Nev.	Ark.	R.I.				
				Ill.		Wash.	N.H.				
							Ariz.				

Only 20 states spent 40% or more of their General Health funds for Local Health Services.

SOURCE Expenditure Reports Submitted To Public Health Service by State Health Departments

SERVICES, FISCAL YEAR

N.D.
Del.
Mont.
W.Va.
S.Dak.
Wyo.
Kans.
Ohio
Texas
Nebr.
Calif.

Mr. Priest. The gentleman may recall that H. R. 267 now before the committee substantially is the bill we reported last year and differs from title V in the omnibus bill.

Are there other questions? If not, Dr. Dearing, before I forget it, Mr. Wilson has suggested, and I think it a very fine suggestion, that if you have available some small reprints of those charts, the committee would like to have those, I am sure. I think they might be very helpful if they are available, and you can furnish the committee with a set of smaller prints of those charts.

Dr. Dearing. We will furnish those and we will furnish also complete details on amendments for H. R. 267, at your request, sir.

Mr. Priest. Are there any further questions?

If not, we thank you very much, Doctor.

Dr. Dearing. Thank you.

(The charts referred to are herewith inserted.)

Mr. Priest. At this point in the record will be included the report of the Federal Security Agency on H. R. 267 and H. R. 785.

(The report referred to is as follows:)

Federal Security Agency,
Washington, May 27, 1949.

Hon. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House of Representatives, Washington 25, D. C.

Dear Mr. Chairman: This letter is in response to your requests of January 12 and 17, 1949, for reports on H. R. 267 and H. R. 785, identical bills to assist the States in the development and maintenance of local public-health units, and for other purposes.

The primary purpose of these bills is to extend and strengthen local health services throughout the United States. Adequate public-health protection for all citizens is best achieved by competent full-time local health services. Local health units are the foundations of the public-health structure in that they provide the basic public-health services vital to each community. It is the consensus of such professional organizations as the American Medical Association, the American Public Health Association, and the Association of State and Territorial Health Officers that available knowledge concerning the prevention of disease cannot be fully applied until all areas of the United States are served by effective full-time local health departments.

The need for extension and improvement of local health services is compelling. There are today 137,000,000 people in the United States who are not served by full-time health organizations staffed to provide minimum local pubic-health protection and services which advancements in scientific knowledge and techniques have made possible. Of this number, 37,000,000 receive no full-time local health services. One hundred million people live in areas in which the existing local health units require an expansion in staff and activities to meet even minimum standards of operation.

A central concept of these bills is that the funds paid to the locality shall be used for the development of an organization to carry out certain common essential public-health services and to serve as a framework into which may be fitted the several specialized public-health programs for which the Congress may choose to give special support. Without such a framework of organization, these specialized programs are seriously handicapped. The provisions of these bills, when full implemented, would assist every community to provide a basic minimum operating staff for public-health work, the lack of which at the present time is seriously impeding general health improvement and the maximum development of special programs in such fields as heart disease, cancer, tuberculosis and venereal disease control, mental health, maternal and child health, including the care of crippled children, and industrial hygiene.

These bills would authorize grants to enable each State health authority to develop a plan for the eventual coverage of the entire State with basic public health services provided by efficient and effective local health units. Local health jurisdictions which meet specified criteria with respect to area, population, financial resources, and personnel will be entitled to participate in the State plan.

Each State would receive from Federal funds a percentage of the expenditures made by the local public health units included in the approved State plan. For the country as a whole, this percentage would approximate one-third of local units' expenditures under the State plans, although the percentage for each State would vary in accordance with the State's average per capita income, with low income States receiving a larger percentage (not exceeding 66⅔ percent) of expenditures than high-income States. No expenditures under a State plan which exceeded $1.50 per person thereunder would be counted. The funds received are to be distributed by the States to the participating local public health units in accordance with methods assuring their equitable distribution and effective use in the extension and expansion of basic public health services.

The bills would require that, within 6 months after enactment, the Surgeon General shall prescribe regulations, with the approval of the Administrator and after a conference of the State health authorities, establishing criteria for determining the population, resources, and number of full-time personnel which the local units are to have in order to participate in the State plan; criteria for determining the equitability of methods for the State allocation of Federal funds among the eligible local health units; general methods of administration under the plan, and the types of services which will be considered basic public health services.

Section 314 (c) of the Public Health Service Act would be amended by removing the present ceilings and leaving to budgetary arrangements and appropriations the amounts that may be used by the Public Health Service for training, studies, demonstrations, and grants to the States for the purpose of developing the central State health organizaion and administering its State plan. In addition, funds appropriated pursuant to section 314 (c), as so amended, would not be available for grants for basic public health services for which appropriations are authorized under the other provisions of the bills.

An important objective of these bills is to channel the Federal funds through the State health authority down to local health units participating in the State plan, and to provide that they be used by the local units for the provision of basic public health services only. The bills also contemplate continuing fiscal support of local health units by the Federal Government, without disturbing our traditional Federal-State relationships.

This Agency is in full accord with the objectives of H. R. 267 and H. R. 785. We feel, however that these objectives should be accomplished through a different approach from that followed in these two bills. In connection with his recommendations for appropriations to the Public Health Service for general health grants to the States the President said in his budget message for the fiscal year ending June 30, 1950:

"I recommend that the present statutory limitation on the amount of such general health grants to States be removed from the Public Health Service Act so as to authorize in later years the provision of larger amounts for the further improvement and expansion of local health services. It is clearly more desirable to follow this course than to add new and separate grant programs or to continue to expand existing specialized health programs."

On May 19 1949 we submitted to your committee a report on H. R. 4312 and H. R. 4313 title V of which contains provisions for attaining the objectives of H. R. 267 and H. R. 785 along the lines of the President's suggestions. Title V of H. R. 4312 and H. R. 4313 would eliminate the present statutory earmarking of appropriations for specialized grants and provide funds for local health services as well as for other special public health programs in the form of a single grant to the States with authority for the Surgeon General by regulations to establish requirements in particular programs which the States must meet in order to qualify for payments.

As we stated in our May 19, 1949, report, the provisions of title V of H. R. 4312 and H. R. 4313 would avoid the complexity and rigidity inherent in categorical grants and permit the States greater flexibility in the administration of the various programs aided by grants administered by the Public Health Service. These provisions would enable the States to develop more complete and better-balanced programs, and to adjust their programs more closely to their special needs.

We would therefore recommend that the very commendable objectives of H. R. 267 and H. R. 785 be accomplished by legislation following the approach taken in title V of H. R. 4312 and H. R. 4313. The provisions i nthat title would, however ,require revision in several important respects were they to be put forward as a separate bill rather than as an integral part of comprehensive health legislation. We would be glad to suggest appropriate revisions in that title should the committee decide to adopt that approach.

If the committee, instead, decides to follow the approach of the instant bills, H. R. 267 and H. R. 785, we would recommend their amendment in the following respects:

1. The bills should be recast as an amendment to the Public Health Service Act (42 U. S. C., ch. 6A). It was the stated purpose of the bill which became the Public Health Service Act to provide "a compact and logically arranged law governing the Public Health Service," and to maintain consistency with that objective any new and permanent functions which may be entrusted to the Service might preferably be created by amendment of the basic law rather than independent enactment.

2. The bills would be improved and their administration simplified by deleting the provisions of section 7 (a) (2) (p. 9, lines 10–14) under which the States would receive an additional amount, not to exceed 20 percent of the sums to which they are otherwise entitled under the bill, "as determined by the Surgeon General after taking into consideration the special needs and the size of the local health problem in each of the several States." This language apparently was inserted to provide for unusual situations, whereas the primary purpose of the bills is to assure basic services for meeting needs common to all localities. Unusual situations calling for funds in addition to those otherwise provided under these bills are so unlikely as to make unwarranted the administrative complications which we believe section 7 (a) (2) would entail.

3. The absence of legislation aiding the establishment and maintenance of local public-health organizations has necessitated at least the partial support of such organizations, and of the essential basic services which they should provide, from funds appropriated by the Congress for the venereal disease and tuberculosis control, cancer control, maternal and child health, and other specialized health programs. As the local public-health organizations and the basic services contemplated by these bills become fully effective, Federal support for them from appropriations for specialized programs will become unnecessary, thereby making possible development to the fullest extent of any of the programs in special fields on which the Congress desires us to continue to concentrate particular attention.

It is our understanding that in prescribing regulations under section 5 (b) (4) of the bills account would have to be taken of the considerations mentioned above; but in order to remove any doubt as to the congressional intent on this point, it would seem desirable to amend section 5 (b) (4) to read as follows:

"(b) Within 6 months after the enactment of this act, the Surgeon General shall by regulation prescribe—

* * * * * * *

"(4) types of health services, including the training of personnel for local public-health work, which shall be considered basic public-health services for which funds may be expanded under State plans, *consideration being given in such regulations to the types of health services for which Federal aid is available under other* provisions of law." [New language in italics.]

4. Several other changes of a minor or technical nature should also be made to improve the bills.

All the suggested changes recommended above were contained in H. R. 5644 (which, together with H. R. 5678, was the predecessor in the 80th Cong. to the instant bills) in the form in which that bill was reported out of your committee on June 12, 1948. (See H. Rept. No. 2327, 80th Cong., 2d sess.)

We are advised by the Bureau of the Budget that it has no objection to the submission of this report to your committee. That Bureau also advises that for reasons stated in our report, H. R. 267 and H. R. 785 could not be considered as in accord with the program of the President.

Sincerely yours,

J. DONALD KINGSLEY,
Acting Administrator.

Mr. PRIEST. Our next witness is Dr. Donald A. Dukelow, consultant in health and fitness of the bureau of health education, American Medical Association.

STATEMENT OF DR. DONALD A. DUKELOW, CONSULTANT ON PHYSICAL FITNESS IN THE BUREAU OF HEALTH EDUCATION, AMERICAN MEDICAL ASSOCIATION, CHICAGO, ILL.

Dr. DUKELOW. Mr. Chairman and members of the committee, I am Dr. Donald A. Dukelow, and I am a consultant on physical fitness in the bureau of health education of the American Medical Association. I appear here today as a member of the staff of that association in support of the objectives of this legislation.

The opportunity was given the association to record its approval of the objectives of similar bills before your committee last year and some of the things I may say now follow in substance rather closely the statement made in 1948. Representatives of the association have recently appeared in support of the general principles of S. 522 which is now pending before the Senate Committee on Labor and Public Welfare.

We, the American Medical Association, have long believed that the existence of effective and properly operated public health units is basic to the maintenance and improvement of the health of our people. Recognition of this conviction was reflected in action taken by the association as early as 1883 when a report was made at our annual meeting for that year covering a survey conducted to ascertain what States and counties had at that time health departments. In the intervening years, our inerest in this subject has remained unabated and while much progress has been made, much more remains to be done.

As illustrative of our continuing interest in the establishment of public health units, the house of delegates of the association, in 1942, adopted the following resolution:

> Whereas a major inadequacy in the civilian health protection in war as in peacetime continues from the failure of many States and of not less than half the counties in the States to provide even minimum necessary sanitary and other preventive services for health, by full-time professionally trained medical and auxiliary personnel on a merit system basis supported by adequate tax funds from local and State and where necessary from Federal sources: Therefore be it
>
> *Resolved*, That the trustees of the American Medical Association be urged to use all appropriate resources and influences of the association to the end that, at the earliest possible date, complete coverage of the Nation's area and population by local, county, district, or regional full-time modern health services be achieved (Proceedings of the House of Delegates, American Medical Association, Atlantic City, June 8–12, 1942, p. 71).

The 12-point program of the American Medical Association for the advancement of medicine and public health contains a prominent point reading as follows:

> PUBLIC HEALTH
>
> 6. Establishment of local public health units and services and incorporation in health centers and local public health units of such services as communicable disease control, vital statistics, environmental sanitation, control of venereal diseases, maternal and child hygiene and public health laboratory services. Remuneration of health officials commensurate with their responsibility.

In commenting on this particular point an editorial in the Journal of the association, February 19, 1949, had this to say on page 528:

> All the health agencies in the United States are urging the extension of local public heatlh units and services throughout the Nation. Again and again leaders have pointed out that almost half of the counties in the United States are without

such services. Through such local public-health units the control of communicable diseases and of venereal diseases may be exercised. Here the vital statistics for the community may be assembled. In such agencies plans may be devised for maternal and child hygiene and for the extension of sewage facilities, which are lacking in thousands of communities. Here also the public-health center may be located and public-health laboratory services maintained. Notwithstanding the forward-looking aspects of this program, everyone should recognize that the greatest lack is in personnel. Our public-health schools do not develop enough public-health officials to meet the need, and technicians in all the accessory professions are also in short supply. Finally, the remuneration of public-health officials is ridiculously small in view of the tremendous responsibilities that they carry for the health of the people.

Not so very long ago the Bureau of the Census issued a report which pointed out that there were at that time approximately 155,100 units in this country apart from Federal and State governments. These included 38,200 county, town, township, or city jurisdictions, 108,600 school districts, and 8,300 special districts. The report of the subcommittee on local health units of the American Public Health Association in 1945 reported that "at present there are approximately 18,500 local governmental jurisdictions, apart from school districts that may be responsible for local public-health service." This same report came to the conclusion that what was needed was 1,200 county, county-city or multicounty units each including a minimum of 50,000 people.

These small health jurisdictions, such as we have in many parts of the country, were developed in the days of the horse and buggy and of dirt roads. In many instances, they do not include a large enough population to afford a full-time health officer, sanitary engineer, and public-health nurses. A modernization of our public health administrative set-up is long overdue and the bill under consideration today, if passed by the Congress, may well supply the needed impetus.

In hearings held last year the association's representative, Dr. James R. Miller of Hartford, Conn., called attention to the fact that the bills then under consideration, H. R. 5644 and H. R. 5678, defined a "local public-health unit" as a governmental authority of a local area authorized to provide in such area "basic public health services." There was contained in neither bill, which were identical, any definition as to what was to be included in the term "basic public-health services." These bills did not provide, however, that the Surgeon General of the Public Health Service might by regulation prescribe the "types of health services" which were to be considered basic public-health services. It was suggested to the House committee that some limitation should be imposed on the right of the Surgeon General to make such a determination, or rather that there should be included in the legislation itself a definition. In other words, it was our viewpoint that an important matter of this sort should not be left for determination by a Federal administrative officer.

In connection with this suggestion, reference was made to the fact that the chairman of the subcommittee on local health units, committee on administrative practice, American Public Health Association, Dr. Haven Emerson, had designated six basic functions of a local health department. These basic functions were enumerated by Dr. Emerson, as follows:

1. Vital statistics, or the recording, tabulation, interpretation, and publication of the essential facts of births, deaths, and reportable diseases;

2. Control of communicable diseases, including tuberculosis, the venereal diseases, malaria, and hookworm disease;

3. Environmental sanitation, including supervision of milk and milk products, food processing and public eating places, and maintenance of sanitary conditions of employment;

4. Public-health laboratory services;

5. Hygiene of maternity, infancy, and childhood, including supervision of the health of the school child;

6. Health education of the general public so far as not covered by the functions of departments of education.

The bills under consideration by your committee today do not attempt to meet the suggestion we made in 1948. They still authorize the Surgeon General by regulation to determine the type of health services which shall be considered basic public-health services (sec. 5 (b) (4) of both bills).

The pending Senate bill, S. 522, as well as H. R. 5644, Eightieth Congress, as reported by your committee while authorizing the Surgeon General to determine what shall constitute basic public-health services, adds this qualifying phrase:

> consideration being given in such regulations to the types of health services for which Federal aid is available under other provisions of law.

It is not entirely clear to me whether this qualifying phrase means that the regulation must limit the types of health services to be considered basic public health services to the types of health services for which Federal aid is now being made available and this uncertainty is created by the use of the word "consideration." It would be possible for the Surgeon General to give consideration to existing grants-in-aid programs and yet formulate a more embracive definition. If it is the intention to make the basic public-health services parallel the types of grants-in-aid activities now engaged in by the Public Health Service, possibly the committee may wish to clarify the language in the pending bill. I am not committed to any particular phraseology to accomplish what I have in mind but if the words "consideration being given in such regulations" in the qualifying phrase were deleted and if there were to be substituted in their place the words "but limited" the meaning of the particular provision would seem to me to be clearer.

For some time it has been the policy of the Congress in initiating various types of health programs to create advisory councils to counsel with the Federal administrative agency or official concerning the operation or functioning of the particular program. That was true in the Hospital Survey and Construction Act, the National Mental Health Act, the National Heart Act, the National Dental Research Act and the National Cancer Act, to mention only recent instances. The bills under consideration depart from this practice; they contain no provision for an advisory council.

May I suggest that consideration be given to providing, in any bill reported by your committee, for the creation of an advisory council to counsel and advise with the Surgeon General with respect to the functions devolved on him by the bill. It would seem to me he would welcome the aid and assistance of members of a council who have had practical experience in the operation of public health units or who have given the subject objective study.

The pending bills, by lines 9–12, inclusive, page 8, require the Surgeon General to approve a State plan if it complies with the requirements specified in it. Too, lines 9–25, inclusive, page 10, and lines 1–4, inclusixe, page 11, would authorize the Surgeon General to stop Federal aid to a State if its plan in its contents or in its administration, in his judgment, no longer complies with the requirements for an acceptable plan. It is not improbable that differences of opinion may arise between a State agency and the Surgeon General with respect to a decision reached by the latter and I suggest that the State agency should be given the right of an appeal, either to the advisory council, if one is created, or to the courts, or both. No such right is granted either by H. R. 267 or H. R. 785.

In concluding, I would like to bring to your attention parts of certain resolutions adopted by the house of delegates of the association at its Chicago, 1948, session, relating to Federal grants-in-aid to States. These resolutions, in part, are as follows:

> Whereas the American Medical Association has repeatedly expressed its adherence to the principle that Federal grants-in-aid for medical and health services should be made available only to those States which can demonstrate a definite need for Federal financial assistance; and
>
> Whereas the extension of grants-in-aid to the States is inevitably accompanied by Federal restrictions and interference in the affairs of the several sovereign States, and accelerates the tendency toward centralized bureaucratic authority over the affairs of local communities and of individual citizens; therefore be it
>
> *Resolved*, By the house of delegates of the American Medical Association that it hereby strongly reiterates its opposition to the extension of Federal grants-in-aid to any State for any health or medical service except where such State has clearly demonstrated an absolute need for such Federal assistance; * * *

Frankly, I am not prepared to suggest any formula to be applied in determining whether a State is or is not financially able to put into operation a specific health program. It seems to me, however, that the recommendation made by the house of delegates has back of it a sound philosophy. If an individual is destitute, the Government may step in and render aid, while similiar aid is not made available to persons not in actual need of help. In the case of individuals, therefore, a distinction is made, as far as governmental aid is concerned, between those who have and those who have not. This analogy may not be complete in every respect, but it sems to me the underlying theory of the action taken by the house of delegates is one that certainly merits the careful consideration of this committee.

Thank you very much for your attention. I shall be glad to attempt to answer any questions.

Mr. Priest. Thank you, Doctor.

Doctor, do you agree that the six fundamental functions of the local Public Health Service unit as listed by Dr. Emerson are in keeping with your own thought on what those functions should be?

Dr. Dukelow. I believe they are, yes, sir. They have been tested out pretty generally throughout the United States, and I think that they are quite a satisfactory coverage of the basic functions of a Public Health Department as would be operated in a city or county unit or a multiple county unit or possibly with some slight additions at the State level.

Mr. Priest. So far as you know, are there any local units that perform functions beyond the scope of those six as listed by Dr. Emerson?

Dr. Dukelow. Occasionally we find health departments that are engaging in mental hygiene administration; the administration of certain controls over cancer, particularly the reporting of cases. But I think many of those would fall within the categories here defined, and I think that it would be quite difficult to find a thing that could be called public health that would fall outside of these six categories.

Mr. PRIEST. I may have one or two other questions later.

Mr. O'Hara, do you have questions?

Mr. O'HARA. Doctor, in your experience do you find that in rural counties, the public-health nurse serves a real practical purpose in connection with the program which you have spoken of in your prepared statement? I am thinking particularly, Doctor, of rural communities where they could not afford or could not finance laboratory and health officers. It could not be done from a financial viewpoint. Now, my question is, Do you find, in your own experience, that some of these rural counties where they have a public-health nurse, who has a county-wide jurisdiction, that that nurse does an excellent job, generally speaking?

Dr. DUKELOW. She does an excellent job as far as she goes. While I was working with a State health department, I looked upon the public-health nurse as literally the infantry of the public-health army. She is the one that is face to face with disease day after day, and fighting the battles of public health almost single-handed. In the State where I had my greater experience, it was not at all uncommon to find counties without a public-health nurse, or to find public-health nurses maybe 1 to a county, the county having anywhere from 15 to 40 or 50 thousand population, and it is a physical impossibility for 1 nurse to provide a service to that number of people that is worthy of the name. She does as good as she can, but I feel that we need more public-health nurses, at least to the standard of 1 per 5,000 population, preferably more, and they should be working under medical direction.

Mr. O'HARA. My own State happens to be Minnesota, Doctor, and we have pretty generally throughout the State, I think probably every county of the 14 in my district has a county health nurse who does a very fine job, very much as you have illustrated. The population of those counties would just about cover the category that you spoke of, from about 15 to 18 thousand to 40 thousand.

On the other hand, her work is supplemented by the fact that they have these public-school nurses. Many of them are consolidated schools, and I am speaking of the towns of any particular size wherein a large number of rural children are brought in by busses. Those school nurses do an excellent job.

Now, of course, each community, practically, has its own either official or unofficial doctor as a public health doctor, and he looks after the sanitation, and health in general.

How general is that practice, which I have outlined, throughout the country, if you know?

Dr. DUKELOW. You have two questions here, Mr. O'Hara, and may I take them one at a time?

In regard to the differential between the so-called public health nurse associated with the health department or the county nurse, which in Minnesota operates under the direction of the board of county commissioners, and your school nurse, which operates under the direction of the board of education, you have some differential. Invariably, your public health nurse, operating within the county, is a certified public health nurse, a nurse who has had graduate training in public health administration. Your school nurse, on the other hand, only occasionally has that specialized training, and usually she is a nurse with the customary bedside and hospital training, with a liking for children, and who develops an experience that makes her usually quite proficient, but of variable proficiency. Many of them do have public health training, to be sure, but not all of the school health nurses have that training.

There is sometimes a duplication of their work, since they are operating from two entirely different local administrations. Although it might be very difficult for some school boards to give up their nurses, it is my opinion if one could cover the community with a suitable number of trained public health nurses operating out of a public health jurisdiction, it would do a much better job in the school than is now being done by school nurses.

The second question has to do with physicians in private practice who conduct a local health department, who are a health officer for a township, a village, a city, or possibly even for the unorganized territories within a county, or I believe in some other States than Minnesota actually serve as a county health officer and simultaneously practice medicine; or often we find a physician, particularly a venerable gentleman, whose years of active practice are long, is moved from private practice of medicine into a job which is labeled "Health officer," and in making that transfer he carries with him the traditions and the practices and habits that he has known all of his life, and proceeds to practice medicine in competition with his fellows, but under the title "Health officer," and usually with an income paid by the Government. Consequently, frictions develop in the community, and a good public health job is not done.

The kind of a health officer contemplated by the legislation which is before you, these various bills that define local public health services, have in mind a public-health-trained physician—a physician, to be sure—who may or may not have had experience in practice, but who in addition has had graduate training in administrative medicine in public health administration, and is competent to do that specialty in medicine which is now being recognized as quite different from private practice.

Does that answer your question, sir?

Mr. O'Hara. Yes, it does.

Mr. Sadowski. I wish that you would expand just a little bit more on the suggestion that you made about the creation of an advisory council to counsel and advise with the Surgeon General with respect to the functions devolved on him by provisions of the bill. How far would this advisory council expand its advisory policies upon the Surgeon General? To what extent and how far should their authority extend, or should they have any authority?

Dr. Dukelow. That is a debatable question. However, it seems the opinion of the American Medical Association that the Surgeon General should have someone who can advise with him regarding various patterns or various programs within the administration of the grants that are here outlined. He does have such an advisory group in the State and Territorial health officers in regard to the actual making of the grants to the States in the development of the formulas therefor and things of that nature. However, he can include under the existing patterns almost anything and call it public health, and it seems that in order to avoid many of the conflicts that do exist between public health and medicine, between the administrative end and the private practice end, there should be an advisory group that can help guide the Surgeon General in the preparation of his regulations so that there will be a minimum of conflict in that area, and all concerned can work together very peaceably.

I would say that certainly there should be a group of professionally qualified people who can consult with the Surgeon General and advise him. How far they can go in their authority, I would hesitate to state, but I would say that their advice to him should bear some weight.

Mr. Sadowski. I would not like to see any such advisory council, have power to such an extent that it could probably dominate and hamstring the Surgeon General. The policies of Congress, of course, should be paramount above the policies even of your great association or committees of your association. In other words, it seems to me that this public health program of necessity must be expanded, and has been very much neglected in the past, and there is so much work to be done in that field and it would not be right to have a committee that would sit there as a sort of a dog in the manger committee on some matters. It is good to give advice, but it should not be carried out to the extent where such an advisory committee could dominate the whole policy of the public health officers or dominate the policies of Congress.

To follow up, is it not true that in practically all of the States, the State health commissions all have advisory councils? The American Medical Association has quite a bit to say in practically every State set-up.

Dr. Dukelow. The cooperation is quite close between the State medical association and the Public Health Administration, and in most States the medical society has some type of advisory group or committee that advises with the health officer and with the board of health if one exists; and in the majority of the States, or at least a very significant number, there are boards of health in which the responsibility of administration or the development of ideas is placed, of some size, 5, 7, 9, or some number.

I doubt very much, Mr. Sadowski, if this group would be a dog-in-the-manger type of thing. I can conceive of that as a possibility, to be sure, but commissions of that type, advisory committees of that type, are serving the Surgeon General and other administrators within the Federal administration in regard to other matters, and it seems that Public Health is broad enough in its interests and embraces enough professional fields so that it could well have some kind of advisory group.

Mr. Sadowski. So far as I know, the relationship has been very friendly and has resulted in a lot of good, but I am wondering whether your suggestion, the one that you are making now, is an attempt to go even a little bit further than the present policy of advising; while it probably is not aimed to have a veto power or authority over the business of the Surgeon General and perhaps indirectly a veto over the policies of Congress—

Dr. Dukelow. I do not see how that could be possible.

Mr. Sadowski. I would be quite jealous of those privileges, and I would not like to see the AMA take over the whole show.

Mr. Bennett. Doctor, I take it that you object, or your first objection here, as I read your statement, is that the present bills give the Surgeon General too much discretion in determining the scope of basic public health services. Is that correct?

Dr. Dukelow. That is correct.

Mr. Bennett. You think that in any bills of this nature the scope of the program should be nailed down and defined?

Dr. Dukelow. I think it should be defined.

Mr. Bennett. Under one of your other suggestions in line with that is the wide discretion given the Surgeon General in approving a State plan, and you have suggested an advisory council as a remedy; that is, an agency to whom a State might appeal the decision of the Surgeon General, as they have the right to do in the case of the hospital-construction legislation.

Dr. Dukelow. That is right.

Mr. Bennett. Have you considered this, that the council provided for in these other bills are appointed by the Federal Security Administrator? In other words, it is a departmental proposition, so my distinguished colleague Mr. Sadowski's fears about the council having a veto or hamstringing the Surgeon General are not likely to occur, because he appoints virtually, or substantially appoints this council, and they are creatures of the Public Health Service. Is that not a fact?

Dr. Dukelow. I believe that that is true in some of the legislation now in operation.

Mr. Bennett. Well, it is true with respect to the hospital-construction situation, and I think it is also true with respect to these various research institutes that we are considering here. As a matter of fact, as I see it, when you give the Surgeon General or his department the right to appoint a council to which you can take an appeal from his decision, you are doing a useless act. And as far as I am concerned, if I were in State health group, I would not think that I would have much remedy if I did not agree with the Surgeon General, if I had to take an appeal from his decision to a board or council that he appointed. Do you think that there is something to that?

Dr. Dukelow. I think that you are quite right. That is, if a board were appointed by the Surgeon General or the Administrator, definitely it would be thinking along the same general lines that they would be thinking.

However, some opportunity to have a group—I don't know, possibly there is provision provided by the Congress in various other legislation where a group of skilled individuals well informed in their special fields advise an administrator. I am not well enough acquainted with laws outside the public health to know whether that is a possibility, and it seems reasonable that it could be developed.

Mr. Bennett. If you are going to suggest a means by which you give a State the right to take an appeal from what they deem to be an arbitrary decision of the Surgeon General, you have to suggest something different than these advisory councils which are a part of the same agency.

Have you given any consideration to the formulas set up in these various bills by which you compute or determine what State gets what from the Federal Government under this program?

Dr. Dukelow. I have considered the formulas. I believe that the statement that was made here in the formal statement expresses the opinion of the American Medical Association, to the effect that this should be definitely supplementary grants-in-aid and that States that are able to stand on their own feet and administer a fairly satisfactory program—and maybe we should say stand on their own budget—should receive less or very little in comparison with those States where there is considerable need. As I recall, we made the parallel between the indigent seeking assistance and tried to compare that with a State seeking assistance.

Mr. Bennett. There again, Doctor, you are doing the thing that you are objecting to under the right of the State to take an appeal. In your statement, as I read it, you suggest that the needs of the particular State be determined. I would think that the Surgeon General would be the one to make the determination as to whether a particular State needed the assistance financially or whether it did not. There you would be doing the thing that you are objecting to on the other side. When you object to giving the Surgeon General arbitrary authority to approve a State plan, that is the thing that you are doing, as I see it.

In other words, is there not some way that someone can suggest a mathematical formula that the average person will understand, instead of these high-powered complicated mathematical formulas in these bills, that nobody, even the authors in some cases, can understand? Is there not some way whereby you could fix a minimum and a maximum, and give the Surgeon General authority, with a minimum and maximum, to determine the allocation that is going to be given a particular State; and from there on let the State spend it as it sees fit?

Dr. Dukelow. As I understand, there have been formulas worked out for the grants-in-aid that are currently being made in other fields of public health in which the Surgeon General has consulted with the Conference of State and Territorial Health Authorities, and there is a provision, I believe, in all of the bills for that kind of assistance from the State and Territorial health officers in regard to the formulas and other things having to do with making the grants themselves.

To be sure, there is a skeleton set-up, but within that the Surgeon General receives the advice of these State health officers, who are the ones who are administering at the State level such grants as may be made by the Public Health Service and the Children's Bureau, or wherever their money may be involved. So that there is, at the level of grants, some advisory service.

There is, however, and to come back to this same point, no advisory service in terms of program, because that is strictly in terms of regulations defining what is set forth in the bills.

It would be my opinion that there should be set forth in the law some definition of what Public Health Service should embrace, within which, to be sure, there could be some definition and, as I suggested, some advisory group that can work with the Surgeon General at that level as well as at the level of the actual making of grants. Possibly it could be the same or similar group.

Mr. BENNETT. You define in the law the scope of activity for the Public Health Service and then, if a State submitted a plan that came within the scope of the act, the Surgeon General would have to approve it; is that your idea? Or would you still leave the Surgeon General with the arbitrary authority, which he evidently has under these proposed bills, to approve a State plan or reject it as he sees fit, and thus have complete and final authority as to what a particular State is to do?

Dr. DUKELOW. There are two factors involved. There is the technical approval of the plan, and then there is the approval of the grant that would implement that plan; and it seems, in the discussion that we have given here, those are two factors. A State may have a beautiful plan, but it may be a State which, within the limits of the grants provided, would not be eligible to receive sufficient Federal money to put the entire thing into effect. It would be assumed that maybe it is above and beyond what is contemplated by local health service. So you would have to consider both the State plan as well as the plans and procedures and formulas, and so on, defined by regulation within the authority of the law for the actual determination and making of the grant.

Mr. BENNETT. Then, from the decision of the Surgeon General, you would think the State should have the right to appeal to some independent body.

Dr. DUKELOW. If the State was unhappy about their treatment.

Mr. BENNETT. Where they could obtain an impartial review of the decision?

Dr. DUKELOW. Yes, sir.

Mr. BENNETT. That is all.

Mr. WILSON. Mr. Chairman, I would like to obtain the thinking of the witness on a question of his appeal, or suggestion for appeal, to a council or to a court; and first I want to point out that in H. R. 267, which is before the committee for consideration, historically there is a provision that "insofar as practicable" this plan, either for the State plan, the approval of the State plan, or for the dishing out of the money, must be after a conference with the State health authorities.

Does not that provision in the bill before the committee, by our subcommittee chairman, Mr. Priest, meet just what you are talking about?

Let me point out specifically, on page 5 of that bill, section 5 (a). It reads thus:

> * * * shall be prescribed after consultation with a conference of the State health authorities, whose agreement the Surgeon General shall insofar as practicable obtain prior to the issuance of such regulations.

And again, on page 8 of the same bill, section 6 (b):

> The Surgeon General shall approve any State plan and any modifications thereof which provide—

and so on. Do not those provisions throw around it the necessary and the only practical cloak of protection against the very thing that you are suggesting, of having to have an appeal to a council or a court?

Dr. DUKELOW. When I studied the bill, it was my impression that those pertained to the making of the grants, to the State plans in terms of the determination of the grant-in-aid and how the formulas should be worked out for that particular State. If that does include what we were discussing here in terms of a program, why, that would cover it.

Mr. WILSON. It definitely does come under the heading, in this proposed bill, of "Regulations," and does refer to the promulgation of regulations.

Mr. O'HARA. Will the gentleman yield at that point?

The thing that troubles me, Mr. Wilson, and I think it is still up to the Surgeon General to decide, first, whether he approves the plan of the State and, if he does not, that means no money; and, if he does, it probably follows that there would be funds allocated then; but I still think that the language you read leaves it within the power of the Surgeon General to decide whether he approves or disapproves.

Mr. PRIEST. If you will yield at that point, I believe the language that the gentleman from Oklahoma read on page 8—that is, paragraph (b) of section 6—I think that language makes it mandatory that the Surgeon General shall approve any State plan that complies with the provisions of subsection (a) of section 5, and that is the section dealing with the regulations and criteria, which must be agreed on after conference with the State health authorities.

It seems to me—and I agree with the gentleman from Oklahoma—that, so far as I can see any practical application whatsoever, these sections, taken together, answer the question of Dr. Dukelow.

Mr. WILSON. Going further into the very next section on page 8 of the proposed bill, H. R. 267, it covers payments to States. It says:

> He shall, in accordance with regulations and after conference with the State health authorities.

So it seems to me that we have nailed it down in the most practical manner, both as to the promulgation of regulations and as to the payment of the money.

Mr. BENNETT. Will the gentleman yield?

The trouble with that reasoning is this, as I see it, that section 5, in promulgating the regulations, says, "he shall follow insofar as practicable."

Now, that leaves to his discretion what is practicable, as I read the language.

Then on page 8, section 6, and also section 7, all go back to the regulations referred to in section 5.

Mr. WILSON. I quite agree with you, and I have been around the Congress so short a time that in my temerity as a freshman I have found in subcommittee meetings that those words, "insofar as practicable," seem to have some sort of magic. I am not sure that I know what they are, but they are magic words; and after all, when you boil it down, do they not have a practical meaning as well as a magic meaning? I have seen it inserted on the House floor to try to arrive at something that can be administered by the administration who has the job of carrying it out—"insofar as practicable."

I would like to ask the witness another question. Do you really feel that there should be a right of appeal to a court, assuming that no council was created? Let us say the Administrator did become capricious in following out the theory, that he might become dictatorial in really refusing to approve a State plan. Do you feel, really, that there should be an appeal to a civil court to go behind and question the reasons for his approval or refusal to approve a State plan?

Dr. Dukelow. I think that that would be desirable.

Mr. Wilson. Why?

Dr. Dukelow. Again, on this question of difference of opinion, the State and local health officers in most instances are sincerely interested in the interests of their people, and they are striving to develop programs and provide services and carry out protective functions that suit the needs of their community as best they can develop them. When one seeks a grant for the conducting of certain programs within a certain community, it is very possible that an administrator or the Surgeon General or some other administrator may take issue with a State health officer, or possibly a county health officer if the grants should be made directly, on the advisability of this program in this locality. There may be a sharp difference of opinion.

If, under those circumstances, the program were not approved and grants were not available, it seems that there should be an opportunity for an exchange of opinion before some competent body that would have judicial authority.

Mr. Wilson. I think that you have a good reason, whether or not it is sufficiently logical to cause it to be inserted in this proposed legislation. I am wondering about that.

But in the history with these other plans, the hospital survey and construction plan and the Mental Health Act and the Cancer Act and the Health Act, have any of those thus far encountered any difficulty just like you were explaining or fearing may happen?

What I am trying to say is this: Thus far, with the experience of these acts, I do not believe anywhere down the line that that thing has happened.

Dr. Dukelow. I am not well enough acquainted with the facts to answer that.

Mr. Priest. I do not at this point care to belabor the question of appeal to a court. I hope our good friend, the doctor, will study the implications of the position he temporarily has taken on that before coming to a definite conclusion. My personal opinion, without going into it at this time, is that such a procedure in a grant-in-aid program would launch us into a field that might present a great many difficulties if we considered such action.

Mr. Sadowski. Along the same lines, it strikes me that if there was an appeal, or provisions made for an appeal to a court, that provision for appeal should be made available to those people living in those counties in the United States who today have no public health services at all, and it should be given to those people who are trying to help to extend these basic health services to all of the people of the United States, and particularly to those counties, to those one-half of the counties in the United States which today have no facilities for public health service whatsoever. That is largely due to the negligence of the local county authorities and to the State authorities, who have done nothing about it. And possibly also some blame could be placed at the doorstep of the AMA, that up to this time they have not exerted all of their influence and all of their advisory powers and capacities to aid those counties.

So if anybody needs an appeal in this bill, it is those people who are not getting the services, and they really need a court of appeal.

Mr. O'Hara. Doctor, the AMA is not a legislative body, is it?

Dr. Dukelow. Well, not outside of their own particular immediate interests.

Mr. O'Hara. Doctor, the discussion which we have had here on this particular subject illustrates the horns of a dilemma which some of us who are interested in the rights of the States, and autocracy and bureaucracy, find ourselves, but let me say this, Doctor: Would it not be true that, let us say, the Surgeon General, if he were to promulgate certain general rules as to a program of the nature which we are discussing, and a State came in with what was not a good program, let us say, from a practical viewpoint, and it was not well thought out, should not the Surgeon General have the right of veto of that program and suggest what ought to be done for a sound program? I am just trying to be practical on this situation.

Dr. Dukelow. I am not going to answer a straight "Yes" and "No," because I can conceive of two situations: I can conceive of a poor plan such as you suggested, and in that instance certainly there should be some instructions or possibly even some wielding of financial pressure, if you will, to help evolve that into a good plan. On the other hand, I can conceive of another alternative where a plan may be in the process of evolution, only part of it is proposed and it appears lopsided at the moment, but it is all that that particular group can handle or digest at that moment. In that case, it seems that there should be an assistance to a State in the evolution, or to a county or local health department, or wherever it may be, in the evolution of a program that may in time reach the goal toward which they are working. But to throw out such a plan which is a beginning toward an objective is entirely a different thing than throwing out what could be called a poor plan.

Mr. O'Hara. I agree, Doctor, that that is a very practical situation, and I recognize the possibility of a certain amount of arbitrariness on the part of a Surgeon General. That leaves a State in a rather bad situation, on which they have no appeal.

As I view it, while the right of appeal, I think, appeals to me as a lawyer, I do not know how it would work in a practical way.

I suppose, Doctor, it is a matter—and the only trouble with some of these things is that they become enmeshed in red tape that makes it exceedingly difficult, sometimes, for someone to cut through them—but it seems to me that if a little common sense were exercised, both on the part of the Federal Administrator and the State, that certainly they would work out what would be an agreed program without too much trouble, do you not think so?

Dr. Dukelow. I think it can be worked out.

Mr. Wilson. The witness stressed the resolutions and the program of the American Medical Association on that subject, and adherence to the long-standing principle of not giving Federal grants-in-aid except where the local community or the State has demonstrated its need, meaning its financial need.

Now, does it not reasonably follow that someone is going to have to decide whether a demonstration has been made of that need? As a practical matter, does it not put it up to some administrator of the Government to say a demonstration has or has not been made showing a need? In the exercising of that power, in the proposed legislation, it seems to me that he is nailed down to the point of having at least annual conferences, and he must have the consultation and he must sit around the table and he must try to get together with the State health authorities. After all, we all have got a high regard for our own particular States, and we believe they have inalienable rights; but it gets it down to the level of the State health authorities to give that advice and counsel to someone who must eventually finally make a determination.

Dr. DUKELOW. The program of determining need is sometimes most difficult, but there is more than the Surgeon General and his associates working in that field of determining need. There are constantly being made studies of communities, some by local groups and local health councils. The State health departments are continuously observing communities and attempting to evaluate their needs. Studies are being made through many communities by the American Public Health Association and by innumerable groups, so that there is a lot of information being gathered which could be good advisory information to the one who must ultimately determine whether there is or is not a need.

It is to bring in that mass of data to give an opportunity for the interchange of opinion that the council was suggested, as someone to assist the Surgeon General.

Mr. BENNETT. I do not want to prolong this, but I have one further observation that I want to make.

It seems to me, Doctor, that one answer to this problem of giving the Surgeon General too much arbitrary authority to approve or disapprove the State plan might be met by doing what you suggest in the first part of your statement, and that is to have the law itself, the legislation itself, set out the criteria or the standards of what is considered a part of local public health services, instead of leaving it, as the bill H. R. 267 leaves it, for the Surgeon General himself by regulation to determine what is considered to be basic public health services. If the bill were modified to that extent, then, with a provision that the Surgeon General could promulgate regulations to carry it out within the intent of the act as it defined the scope of public health services, it seems to me that you would obviate a lot of difficulty you are thinking about, where the Surgeon General not only has arbitrary authority to approve a State plan, but also has the final authority to define the scope of local public health services.

Dr. DUKELOW. I think that your suggestion would be a happy solution.

Mr. BENNETT. That is all.

Mr. O'HARA. Doctor, I appreciate that the grant-in-aid hospital program is much simpler than a program dealing with general public health, but so far as I know—and I believe we would have heard from it in this committee in some of our hearings—I have never heard a word of complaint as to the failure of the Surgeon General to approve a plan of a State in the hospital program.

Mr. BENNETT. As I understand it, at the present time there is no State plan required as far as public health services are concerned. This is something new.

Dr. STOCKBURGER (professional committee staff). There are State plans required in the hospital bill, also.

Mr. BENNETT. But I understood from Dr. Dearing this morning, that the present law does not require the submission of a State plan insofar as local public health programs are concerned.

Dr. GRANING. Annual plans are provided in all public health programs under the present law.

Mr. O'HARA. Doctor, do you know of any complaint in the administration of the so-called hospital program, you yourself?

Dr. DUKELOW. I can think of none.

Mr. O'HARA. As I said, that is a much simpler program than is envisaged in this bill, that is true.

Dr. DUKELOW. Of course, one always hears rumors and rumors, but I cannot cite an instance.

Mr. PRIEST. If there are no further questions, we thank you very much for your patience in answering questions, and for your statement.

Dr. DUKELOW. Thank you for the privilege.

Mr. PRIEST. The committee will stand in recess until 2 o'clock.

(Thereupon, at 12 o'clock noon, a recess was taken until 2 p. m., of the same day.)

AFTERNOON SESSION

(The subcommittee reconvened at 2 p. m., upon the expiration of the recess.)

Mr. PRIEST. The committee will come to order. When the committee recessed this morning, Dr. Vlado A. Getting was ready to testify. We are very happy to have him as a witness at this time.

STATEMENT OF DR. VLADO A. GETTING ON BEHALF OF THE ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICERS

Dr. GETTING. Mr. Chairman and members of the committee, I am here as representative of the Association of State and Territorial Health Officers, an organization composed not only of the State health officers as such but also of constituent subcommittees which includes various experts as sanitary engineers, directors of child health, and directors of local health services.

We constitute a highly professional organization which is concerned not only with the planning of grants-in-aid and their administration but to a greater extent, with program development. To illustrate this and to indicate the extent to which our organization has had conferences with the Surgeon General and the Director of the Children's Bureau, I would like to make available to the committee a copy of the proceedings of the forty-seventh annual conference, which will affirm the fact that more than four-fifths of our work relates to program planning rather than to the administration of grants.

Our association, therefore, welcomes this opportunity to discuss before you the merits of the local health service acts.

Over a period of many years, we have constantly endeavored to do everything possible to promote local health units. On November 15 to 17, 1948, the Association of State and Territorial Health Officers passed a resolution, which is attached to my statement, as appendix B, in which we placed first and highest priority on the development of local health units.

We believe that the passage of this bill for the local health units will be the most important single piece of health legislation that Congress can achieve. We are very sincere in bringing that to your attention because it is our belief that the local health department, which is primarily the service unit, ultimately brings the benefits of preventive medicine and public health to the individual citizen.

Now, because of the lateness of the hour and the number of witnesses who are yet to appear, Mr. Chairman, I would like, with your kind permission, to present some of the high points of my statement and perhaps be allowed the privilege of replying to some of the questions which have been raised so far in the testimony presented this morning.

I wish to call your attention to the amended bill on local public health services which the House Committee on Interstate and Foreign Commerce brought out last year in their report No. 2327, I believe the reason why this bill was not reintroduced into the Eighty-first Congress is because many new members have joined the committee. I do feel that the association, as a whole, recommends to your committee the serious consideration of that amended bill as the preferred form in which this type of legislation be passed.

We feel that S. 522, which is in effect your report with one addition, namely, the direct assistance to schools of public health by the Public Health Service, and with which we are heartily in accord, is to be highly commended. We sincerely urge that your committee consider that as the form in which the final report be issued. H. R. 267 and H. R. 785 do not provide for any direct financial assistance from the Public Health Service to schools of public health as does S. 522. We believe that that provision of S. 522 might well be included in the report of this committee in amending H. R. 267, H. R. 785, H. R. 4312, its companion bills, and H. R. 4918. It is our feeling that it would be impractical to pass the local health service sections of these bills unless the sections pertaining to the training of personnel were also passed or amendments made to the local health service sections providing for the training of personnel to man the local health units.

For a brief moment I would like to discuss the fact that under the Public Health Service Act, Public Law, 410, section 314, paragraph (c), as it now stands, it is possible for the Public Health Service and the States to make grants available to local health units; but, as has been explained this morning, that has not been reasonably nor practically accomplished and only a very small proportion of Federal grants-in-aid are now made available to local health departments. Most of the funds are being utilized within the State departments of health.

In 1948, the Bureau of the Budget recommended that instead of passing a special act for local health units, this section, namely, section 314, paragraph (c), of Public Law 410, be amended to allow of increased assistance to local health departments. The House decided to remove that. Actually, the amount of money which is now made available to the States under this general grant has been so small as to be insignificant in meeting the need for the extension of local health units.

It is our understanding that Congress nevertheless wishes to identify all funds which it appropriates and wishes to be assured that the money is expended for the purpose for which it is appropriated. As administrators, on the other hand, we would naturally prefer to have all of our funds placed in one single budgetary item, thereby giving us the greatest flexibility as well as the greatest ease in administration of a program.

However, we feel that as it is necessary to identify funds, the passage of a separate local public health service act would not only accomplish this purpose but would assure that all of the money be expended for local health units.

For this reason we commend the passage of a specific local health service act rather than an amendment to section 314, paragraph (c).

We have made a study of the probable amount of money which would be required under this local health service act, if it were to become a law. These estimates were made on the basis of existing local health units, plus new units which would be established, if personnel were to become available. Now, we estimated on the basis of this study that during the first fiscal year of complete operation—and I must amend my statement by saying that instead of 1950 that would probably be 1951—we would probably need, about $45,000,000, for the fiscal year, and about $30,000,000 for the current fiscal year in which we now find ourselves. May I repeat that this estimate is based upon the ability to expand new units and upon the availability of personnel.

As I indicated before, we feel that this act is extremely important in that it would make available to all of the people regardless of their location, creed, color, sex, or economic status, the preventive medical benefits which are not now available to everyone.

We believe that this bill has no controversy. In that regard I wish to differ with one of the other witnesses who seemed to indicate that there was some difference of opinion between the American Medical Association and perhaps the public health administrators as to what is good for the people. In that regard, I want to file with the committee the latest resolution of the American Medical Association, which was passed in December, 1948, and also their definition of "public health," which reads as follows:

> Public health is the art and science of maintaining, protecting, and improving the health of the people through organized community efforts. It includes those arrangements whereby the community provides medical services for special groups of persons and is concerned with prevention or control of disease, with persons requiring hospitalization to protect the community and with the medically indigent.

The resolution, which I wish to file, in effect, calls for the board of trustees of the American Medical Association to be commended for its efforts in furthering full-time local health units and to be urged to continue actively all proper procedures to the end that local public health service shall become adequate throughout the entire Nation and not only in some States.

(The resolution referred to is as follows:)

HEALTH UNITS FOR THE NATION—RESOLUTION ADOPTED BY THE HOUSE OF DELEGATES OF THE AMERICAN MEDICAL ASSOCIATION AT ST. LOUIS, MO., DECEMBER 2, 1948

Whereas no amount of medical care of persons already sick will substantially reduce the incidence of illness; and

Whereas the traditional position of the American Medical Association has been one of firm support of public health services, in fact, this constitutes a major element of the 10-point national health program of the American Medical Association; and

Whereas large numbers of local areas and counties in the United States are not now and never have been covered by adequate sanitary and other public health services; and

Whereas the Surgeon General of the United States Public Health Service has announced that one of his first major objectives is assistance in development of local health units throughout the Nation to meet this fundamental need; and

Whereas the medical profession has now an opportunity to exert constructive leadership in this matter, through the national constituent State and component county medical societies: Therefore be it

Resolved, That the house of delegates reaffirm its abiding interest in the necessity for the provision of full-time modern public health services at the local and community level, including sanitation and all the services usually considered essential for the preservation of the public health; and be it further

Resolved, That the United States Public Health Service be commended for and encouraged in, its efforts for the further development of local health units for these purposes; and be it finally

Resolved, That the board of trustees be commended for its efforts in furthering full-time local health units and urged to continue actively all proper procedures to the end that local public health service shall become adequate throughout the Nation.

Dr. GETTING. Now, what are the functions of the local health department? They are threefold:

(1) The prevention of illness and injury and the minimizing of disability and severity of disease;

(2) The prolongation of life and prevention of untimely death;

(3) The improvement of individual health.

While there had been six classic functions defined at the National Health Assembly by the section on local health services, a seventh has been added. I would merely like to call your attention to this seventh, which is the control and prevention of chronic diseases, including the development of educational and diagnostic programs for the prevention and amelioration and cure of chronic diseases and their complications and I believe that your committee in its report last year did include chronic diseases as a basic function of public health.

Mr. Chairman, rather than cover the need and the saving of life that would come from the development of such units, I would refer you to the statement on page 6 of my testimony, and will proceed to some of the discussions of the more pertinent basic requirements of a local health service act.

The basic provisions are simple. It should allow financial assistance, preferably on a per capita basis. The formula set up in H. R. 267 is entirely satisfactory, namely, 50 cents of Federal money to $1 of local funds for the extension, expansion, and maintenance of local health departments.

As a State commissioner of public health and as a former local health officer, it has been my experience that it is the local unit of government which is primarily a service unit and which has direct contact with the people. The passage of a local health service bill would make available basic health services to the people through the unit of government which is closest to them. Since the needs of the people are best known to those who live and work among them, the local health officer and his staff, who are a part of the community, are able, through daily contact, not only to give direct service but to be constantly informed of the changing conditions and needs for community health.

Joint planning through community health councils enables the health departments to develop efficient and administrative public health programs. Unfortunately, community and State assets, as already explained, are insufficient to meet these demonstrated health needs, and it is for that reason that the State health officers endorse wholeheartedly this type of legislation which would make additional funds available for the promotion of local health services.

Under these various proposals, each State health department is required to make a survey and plan for the total coverage of the geographic area of the State so that the entire State would be covered with local health units. In this regard, I would like to call to your attention for one State, my own, Massachusetts, a public document entitled "Report of the Special Commission To Study and Investigate Certain Public Health Matters." It is a report of a legislative research commission which contains, on pages 50 to 67, the State plan for the development of local health units. As a matter of fact, we expect that a bill which is now in the third reading before our State senate will be passed this week, making unions of local health departments into population units of 35,000 to 50,000 not only voluntary but compulsory at the end of a period of 10 years. We believe that this will make it possible for us to develop in local New England towns efficient and economic health departments.

I have here copies of the Massachusetts Health Journal, a publication of the Massachusetts Tuberculosis and Health League, which presents an action program and in which there are published a message from His Excellency the Governor of Massachusetts and statements of various prominent public health and private citizens as to the need and the method of developing such unions in Massachusetts.

Similar preparations are going on in all of the States. Some States have already developed especially good plans and are prepared to go ahead with them. What is sorely needed, however, is financial assistance which passage of this local health service act would make possible.

These bills would make available to the State departments of health for distribution to their local jurisdictions, grants-in-aid, administered by the Public Health Service. Distribution of funds would be in accordance with the State plan and formula. The bills further provide that personnel employed under such acts shall be safeguarded by adequate personnel standards on a merit basis or a State civil service system. The Federal Government is assured of the proper and equitable distribution of funds and of their use for purposes intended as the Suregon General may, from time to time, call for such information and reports as he may require.

The Surgeon General is given the necessary authority to make regulations. Such regulations shall be prescribed by the Surgeon General after conference with the State health officers whose agreement the Surgeon General, insofar as is practical, shall obtain prior to the issuance of these regulations.

May I, at this time, state that I have been a State health officer for 7 years. During that period, I have known of no single occasion when the State health officers were a bit backward about expressing their opinion either to the Surgeon General or the Director of the Children's Bureau. Nor have I known any occasion in which the Surgeon General and his staff did not uphold their point of view. Nevertheless, the relationships which have existed between the Public Health Service and the States may serve as an example to be followed by other governmental agencies in matters of reciprocal interest to the States and the Federal Government.

For 47 years, the State and Territorial health officers have been consulting with the Surgeon General. We believe that the Surgeon General is as interested in the welfare of the people as we, and has no other objective in mind in establishing regulations. We have known of no complications which have arisen which would make any change desirable other than that which is already described in H. R. 267.

We, the State health officers, are not appointed by the Surgeon General. We are appointed by our respective governors or boards of health. Therefore, we are not in any way responsible to the Surgeon General for any advice which we may give him. The Surgeon General pays serious attention to the advice which is given at these conferences. The document which I have made available is an example of the type of proceedings which are held.

I think it is entirely undesirable to have another advisory group. The Surgeon General would then be in a dilemma. He would be getting advice from the Association of State and Territorial Health Officers. He would also be getting advice from a second advisory group. It is possible, in my opinion, for two different advisory groups to give the Surgeon General two different types of advice, thereby confusing the issue.

I do not believe there is any reason to even conceive of the necessity of anything like this going to court. If a court were to rule on this, it would not rule on a matter of fact but upon a matter of procedure. In dealing with State government, I am sure the Surgeon General would see to it that all the necessary legal procedures are followed, so that the Surgeon General's decision, notwithstanding anything to the contrary, would still be upheld by the courts, so it would really be a delaying issue. Those appeals to the court take a year or two. In the meanwhile a fiscal year has expired and the State health agency is in a fiscal and administrative dilemma which I think would be unsolvable.

I therefore heartily recommend that the advisory capacity of the State and Territorial health officers, who incidentally are all members of the AMA, but who do not act in the capacity of legal delegates to the AMA, be continued and that there be no separate and additional advisory group introduced and that there be no reference to any court of any decisions. The matters can be discussed frankly with the Surgeon General and with the Federal Security Administrator. If necessary, they can be called to the attention of Congressmen, both Senators and Representatives, who could work the matter out with the State administration officers.

As to a differential diagnosis of the various bills, the discussion I have given thus far would apply to the local health service acts as such, and also to title V of the National Health Act of 1949. These bills, in their respective sections, are substantially the same as S. 522, and the amended bill reported last year by the House Committee on Interstate and Foreign Commerce of the Eightieth Congress.

However, H. R. 4312 and its companion bill, S. 1679, the National Health Insurance and Public Health Act, set up a different pattern for the administration of health grants by the Federal Government.

The main difference is that all categorical grants are done away with and a single health grant is substituted.

Under regulations made by the Surgeon General, the Public Health Service may withhold from a State a portion of its allotment if such State does not comply with regulations requiring that at least a portion of the amount be utilized for categorical programs.

The State Health Departments have always been critical of having a separate grant for each categorical activity which is must administer. It would be administratively much more desirable to have a single grant which the State health officer would have some discretion in applying to meet the particular needs of his State. It is not clear, however, to what extent the Surgeon General could regulate the subdivision of a single grant in H. R. 4312. Therefore, it is possible that although a single grant might be made available under title V of H. R. 4312 and its companion bills, by regulation, the Surgeon General could make such a grant just as restrictive as the many categorical grants now established.

It is, therefore, suggested that some definite limitation be placed upon the Surgeon General's ability to make such regulations, as, for example, prior approval by the Association of State and Territorial health officers, of regulations pertaining to establishing limits on a single subdivision which could apply as a requisite for States in obtaining the grant. In this way it would be possible to have the States vary the proportion of their grants which they would expend for a single category. Thus, one State may expend a greater proportion of its grant for heart disease than another, and yet each State would expend at least a minimum percentage for heart disease. For each category, there would thus be a minimum proportion which each State would be required to expend. However, the amounts which a State would be required to expend would have to be substantially less than the total amount of money available.

For example, States might be required to expend not less than 5 percent for tuberculosis, 5 percent for heart disease, 5 percent for cancer, 2 percent for occupational hygiene, 30 percent for local health, 5 percent for venereal diseases, 3 percent for training personnel, and 5 percent for mental health. Thus, 60 percent of the funds would have to be expended to meet the minimum regulations of the Public Health Service, leaving at the discretion of the State health officer the remaining 40 percent. It is to be understood that these percentages are not figures recommended by the association, but are used merely as a numerical example.

It is the recommendation of the Association of State and Territorial Health Officers that no specific definition of public-health services be attempted in any of these bills. If a specific grant for local health services be made, we recommend that it be so labeled without definition of the term "local health service." It is felt that a proper definition of "public health service" or "local health service" can be made by the Surgeon General with the approval of the association and the Federal Security Administrator.

The reason we say that, sir, is because public health is a rapidly developing science. The AMA has gone as far as to acknowledge it as a specialty by creating a board in public health and preventive medicine this past year. The field of public health is moving ahead rapidly. There has been more progress in this field in the past 10 years than in the preceding generation and perhaps even in the century before that.

It therefore would not be in the interest of the public to define either "local health services" or "public health services" legally in a legislative act.

May I take this occasion to remind the members of the committee that grants-in-aid are also made available through the Children's Bureau under title V of the Social Security Act as amended, for maternal and child health and crippled children services. It is our suggestion that such programs be pooled into the single grant, if there is to be a single grant for health services.

We further recommend that the School Health Services Act of 1949, if enacted, and which is being heard tomorrow, be treated in a similar manner. If we are going to have a single grant, let us have a total single grant from the Public Health Service and let it be administered on a State level through the State health departments. A single grant would make for far sounder administration in the handling of Federal moneys by the States as well as in the total requirement of reports, budgets, and programs, to be submitted.

At the present time, there is considerable difference in the amount of details required by the Children's Bureau as compared with the handling under the Public Health Service. It is the hope of the State health officers that sufficient identification of funds for particular programs would still be possible under this method of administration. This identification would appear in the budgets, audits, as well as in the annual reports of expenditures.

It is our feeling, therefore, that Congress could identify the utilization of funds in one grant as well as they can in separate categorical grants.

Here is where we find a little difficulty, however. Unfortunately, it has been our experience that legislators are not apt to react favorably to a single categorical formula. Successful passage of legislation is motivated by the interests of constituents and Congressmen for a particular program. Some people are interested in cancer because their father or mother had cancer. Some Congressmen are interested in heart disease because they have heart disease. Some are interested in tuberculosis because they have had an unfortunate experience with tuberculosis among their families or friends.

There is, therefore, considerable hesitancy on the part of some of the State health officers in recommending that all the grants be pooled in a single grant since it is felt that the total made available for public health might therefore be lessened. The association feels, therefore, that the passage of a local-health-service bill is preferable because it would assure the furnishing of basic health services to a far greater extent than a single grant which might not have the necessary increased appropriation from year to year and which would, of necessity, not earmark as much of the money for local health units as would a special act for this purpose.

Time does not permit nor do I feel particularly competent to discuss the highly technical procedures of an equitable and just formula for the distribution of funds among the several States. The health of the entire Nation depends upon the good health of all the people of all the States, and the health of one citizen affects the health of another citizen in another State. It is good national security for us to help one another.

However, there should be an evaluation of need and the cost of meeting the need in any formula. The quality and quantity of public health to which an area is accustomed must be taken into consideration. There is also a limitation in the ability of a State to expand its services, depending upon the availability of personnel and facilities.

For these reasons, we favor a formula based not only on population and financial need, but also on an evaluation of public-health need.

Such an evaluation is now made under section 314 of the Public Health Service Act, and is also included in H. R. 4312, but is not included in S. 522, H. R. 267, H. R. 785, and H. R. 4918. A proper and equitable determination of health need can be made on the following basis; namely, (*a*) the extent of the health problem as indicated by morbidity and mortality statistics; (*b*) the cost of rendering health service; (*c*) the ability of the State to expand its program; and (*d*) the quality and quantity of health services usually practiced in the State.

In conclusion, as spokesman for the State and Territorial health officers, I wish to emphasize that local health departments are the basic public-health organization of the Nation. Not only will local health units improve our opportunity for national defense in that we will have more young men and women reaching adult life with less defects, but, in case of attack upon our shores, whether it be by atom bomb or in any other form, local health departments will prove invaluable in administering aid to displaced populations, the injured and the sick.

Since disease knows no political boundaries, the total coverage of the Nation with adequately served local health departments is a prerequisite to American economy. The saving of approximately 190,000 lives a year is made possible by the extension of these essential medical and public-health services through Federal grants-in-aid.

We call your attention to the need for assistance, from both State and Federal appropriations, in the extension of these services. Each State should forthwith proceed with its planning for a total coverage of the State with adequately staffed full-time local health units.

We therefore sincerely urge the passage of legislation enabling the development of such units. We prefer to see this done by a passage of a separate local health service act which would preserve the codification of the Public Health Services Act. We urge that there be included the training of personnel to man such units which is a prerequisite if we are to make available to all of the people all of the basic essential health services.

I believe, Mr. Chairman, that that covers the basic contents of my statement.

I would like, however, to call attention to several issues which have been raised this morning. One is the desirability of limiting by definition the activity of a local health department. I referred to that in my testimony.

I wish to repeat that in the opinion of the health officers, we do not believe that such definition would be in the public interest, if a new program be developed. It would mean that we could not make local health money available for a new program until the bill were amended by Congress. It would therefore tend to arrest the development in public health which should go forward rather than stagnate with or without Federal funds.

I have discussed the advisability of excluding an advisory council since that function has for the past 47 years, before we had Federal grants-in-aid, been served by the Association of State and Territorial Health Officers. That association is concerned not only with the detailed administration of grants, but also with the analysis of programs and the development of new programs which are of benefit to the people.

We have indicated to you that there is no occasion for appeal to courts as we feel that that would unnecessarily delay the administration of the program and serve no useful purpose whatsoever.

Finally, I wish to call your attention to the fact that there is no real conflict, as has been implied, between public health and the practice of medicine. The State Department of Public Health in Massachusetts was established as a result of the action of the Massachusetts Medical Society. I serve on numerous committees of the medical society. In fact, at the last annual meeting, they passed a resolution calling for the department of public health to attempt a new program, namely, the development of five health protection pilot clinics which they would help to sponsor, together with many other voluntary organizations or agencies.

As public-health officials we are able to see and evaluate programs at the operational level and the service level. We see the intimate cooperation enjoyed by the private practitioner who is really the keystone of preventive medicine and the health officer, who is the keystone of public health.

Thank you, Mr. Chairman and gentlemen.

Mr. Priest. Dr. Getting, your statement is characteristic, in one respect, of all your statements before this committee in that it answers practically all of my questions without my having to ask any.

I appreciate particularly what you have said about the relationships between the Public Health Service, the State health agencies, and the private practitioners in the field of medicine.

I have been rather closely associated with the Public Health Service by virtue of the fact that I have been on this committee for a number of years, and I think what you said about the relationship of the Public Health Service with the States and other subdivisions of government might well be a pattern for relationships between all Federal agencies and State agencies. To me it has been very encouraging and heartening to see this fine relationship which I have observed through the years. I appreciate your emphasis on that particular question.

Now, personally, I agree with you also that because of the peculiar circumstances that might be involved in the health program, it is better to have some flexibility insofar as the definition of what public health service is. That is my personal viewpoint, granting the right to the good doctor who appeared before us this morning and others to have a different viewpoint. I feel that this is a growing, developing thing, and needs some elasticity, some flexibility; and I just have enough confidence in the men, whoever they might be, who will be in charge of a health service at the State and Federal level to believe that they are not going to make any very grievous errors.

There are some other members of the committee who have some questions, I am sure, they want to ask you. Mr. Biemiller will return from a roll call in a few minutes. I am sure Mr. Bennett has some questions he wants to ask you. In the meantime, if you will just be available so that you can be called back for some questions, I will say again that we appreciate your appearance before the committee.

Dr. Getting. Thank you, sir.

Mr. Priest. In the meantime, Dr. Emerson, if you care to proceed with your original statement, we will be happy to hear from you next.

STATEMENT OF DR. HAVEN EMERSON ON BEHALF OF THE NATIONAL HEALTH COUNCIL AND NATIONAL ADVISORY COMMITTEE ON LOCAL HEALTH UNITS, NEW YORK, N. Y.

Dr. Emerson. Mr. Chairman and gentlemen of the committee, I represent not only the American Public Health Association but the National Health Council and particularly its National Advisory Committee on Local Health Units. I will go into a little detail on the basis of that representation.

This is a voluntary association of something over 60 Nation-wide and nationally organized agencies concerned with health and welfare of the people of the United States. This body is an unprecedented organization for the creation and support of precisely the kind of legislation your committee reported on last year and which has been expressed in S. 522, on which we recently had hearings.

I am a member of the board of health of the city of New York and was formerly commissioner of health in that city. I would like to say, as an introduction, that I know of no word of Dr. Getting's statement that I would differ with. I would like to emphasize the particular points he made with respect to the competence of the State and Territorial Health Officers as a proper reference and advisory committee for consultation by the Surgeon General.

I would call to your attention the fact that the proceedings of the State and Territorial Health Officers constitute an encyclopedia of the very best public health practice in the United States over this half century. There is no problem that has not been competently referred to adequate committees for their solution. It would be unwise for us to consider the creation of any other advisory body in relation to the operation of such acts as are under consideration here.

There are two notable aspects of the bill—I speak of the bill as if there were one bill instead of half a dozen, but you will understand what I mean; that is, the spirit of the bill which your committee reported on last year and which is included in several bills now. I am very much of the opinion that this is worthy of separate action, and I state that for this reason: That the Congress has been pouring money prematurely into fields for which there was not adequate administrative preparation for its use. If you had spent the money you have poured into some of these categorical topics, first for the creation of a structure of local public health, you would have gotten a great deal farther, whether in tuberculosis, venereal disease, cancer, mental hygiene, or other programs.

This bill resembles closely the Hospital Survey and Construction Act in that before Federal assistance to local community health services can be granted, a State must have given exact accounting of its present health organization and services at the local or community level. May I repeat that, because this was a matter of question at this morning's session. Before Federal assistance to local community health services can be granted, a State must have given an exact accounting of all its present health organization and services at the local or community level.

On the basis of the needs so disclosed, it must then offer an official State-wide program designed to bring to every square mile and population unit within its borders at least the basic minimum public health services indispensable for the application of the sciences of preventive medicine.

May I stop there a moment and distinguish between a comprehensive description of public health as a growing and expanding field of public service and what is described here as the basic minimum public health services that are indispensable. We can develop many other fields, but we cannot get along without any one of those six that have been mentioned. We can divert to other functions, hospitals or others, some of the fields of diagnosis and care of the sick; but it is impossible to run a health department in the modern sense without at least those six basic minimum services. We are proposing a floor under the structure of public health, not a ceiling for its further development.

The formula proposed to aid more generously the economically disadvantaged States and regional populations than the advanced and wealthy States is sound. The Federal Government is well protected against abuse or diversion of its aid for purposes other than those intended. The local community is not to be softened by careless generosity or to be relieved of the primary health function of such local government to provide for health services to its utmost ability out of its own tax resources.

The principle is recognized that preventable disease in any county, city, or region is a hazard and a handicap now or for the future for neighboring or distant local and State governments. Since practically all the direct personal and family health services in the United States are provided by local government, it is sound Federal policy and evidence of an enlightened national self-interest to see that no people anywhere under our flag lack these basic services upon which our national survival, industrial progress, culture, and human reproduction depend.

Neither State nor Federal Governments can do, under our Constitution, what local governments are authorized and required to do to protect the public health. This bill is excellent in its principles and will accomplish what is intended, namely, hasten completion of the process of total coverage of the Nation with full-time local health services under qualified professional direction, an undertaking of local governments begun as early as 1865 and gradually extended but still covering somewhat less than 70 percent of our people.

I wonder if the committee realizes that on the date when the first full-time local health service covering two or more counties was established in 1865, the country, as a whole, did not have 40,000,000 people, and yet there are now 40,000,000 people without any such services at all. We have grown faster in population than we have expanded in the application of these services.

In 1865 the New York Metropolitan Board of Health was created and has been in continuous operation, under single direction, to this present day.

Now, although that is a long time to have a local health department function, a great deal of the safety and preeminence of that aggregation of people has been due to this forunate circumstance of having a local health department operated out of local money, and only recently with State aid, for almost 85 years.

At that time our country lacked local services almost everywhere. No one State or locality can be entirely safe from preventable diseases until all States are covered by modern, full-time local health departments. This is indispensable whether for the emergencies of peace or for the catastrophies of war.

The second matter of primary importance is more quickly dealt with. In the 7 years since the recent movement was started to bring local health services to the 40,000,000 of our people who lack these, there has to my knowledge been no opposition to the goal or the method expressed by any professional, technical, civic, popular or other body in this country. A remarkable and most encouraging unanimity of supports for precisely the measures written into the bills under your consideration—and I will not stop to try to cover them—but the bill which you reported last year and S. 522 represent the simple elements that I should describe. In fact, I believe a widely held professional opinion is to the effect that when the logical, practical, and Nation-wide effects of the Hospital Survey and Construction Act and of the local health-unit bill before you here, if enacted into law, are thoughtfully observed over a decade, there will be a diminution in the clamor for elaborate, costly, and revolutionary proposals for medical care and ultimately a cessation of the demand for any kind of compulsory, federally controlled system of sickness insurance.

If there are details relating to public health administration, its costs, functions, and results at the local level which you believe I can discuss for your information, I am entirely at your disposal.

The bill seems to me to express the essence of the democratic principle and the proper relation between Federal and State governments in the interest of the people's health.

Permit me especially to call your attention not only to the necessity of the basic health obligations of local government through the organization of well qualified health departments but the inherent demand for trained personnel to staff the new departments which will be needed. I will pass over that because that matter has already been gone into.

Permit me also to emphasize the dependence of each of the special official and popular drives to promote control of the several important disease categories upon the presence in every area and community of a permanent organization and professional leadership in public health. Briefly, the special fields of cancer, tuberculosis, venereal disease, and mental disease, all await the preparation of a delivery system at the retail point in the local community. Without those, many of these have lost a great deal of their force and have wasted considerable of their money. If you have no general practitioners of medicine, specialists are of little use. If you lack local health departments, special fields of disease control can not be thoroughly cultivated.

I will say further that State and Federal health services will remain seriously handicapped.

This bill has the enthusiastic support of the medical profession, as you have already heard, of the public health professions, of the national voluntary health associations, such as the National Health Council, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, and of some 60 and more Nation-wide popular organizations concerned with health protection such as the

Congress of Parents and Teachers, the International Lions, farmer, labor, and civic groups and women's clubs. I should like to put in the record the resolutions that have been passed—they are appended to my statement—and which have been received by us from these various bodies.

In the briefest manner, let me make real to you what local health services mean to individuals and families. The local health officer is the source of day-by-day information and advice as to the health of the community, warning of precautions needed to avoid epidemics, to maintain nutrition, to guard the expectant mother, infant, and school child against neglect of personal hygiene, to see that all occupations are safe from hazards of dusts and poisons, to assure the cleanliness of foods, milk, water, public eating places, to see that insects, rats, and other vermin are controlled.

The health officer, the sanitary engineer, and above all, the public-health nurses of the local health department, interpret science and sanitation to every family the year-round, to school children, farmer, foreman, and workman. Public health is a personal experience throughout life, and the local health department is the guardian, teacher, and translator of the sciences into every-day practice of every-day folks.

When you enact this bill you will have gone far to complete a structure of medicine in Government without which the best of health cannot be had.

You are considering, along with the local health units bill, sections of other bills that are designed for the same purpose, namely, to provide Federal aid to States for State and local health work. I have reviewed briefly title V of H. R. 4312 and H. R. 4313, and the local public-health units section of H. R. 4918. Each has merit. But without going into details, I might suggest that an advisory council from the State and Territorial Health Officers' Association, as provided for by H. R. 267 and H. R. 785, would seem to be preferable to the Council provided for in H. R. 4918, and that the continuing responsibility for Federal participation if the State plays its expected role, as in H. R. 267 and H. R. 785, gives more assurance perhaps that the purposes of the bill will be carried out than may be expected from the other bills.

I want to emphasize that my concern and that of the agencies I represent is that no person in these United States shall be without the benefits of modern biology and preventive medicine through the agency of an adequate local health department.

These bills, especially H. R. 267 and H. R. 785 and their companion Senate bill 522, seem to be the simplest and most direct way for the Federal Government to aid in this program.

But with whatever mechanism you choose, I beg of you to make sure of the Federal Government's part in this basic and important task of local governmental responsibility for the health of its citizens without which there can be neither individual nor community well-being, at the modern level.

I may say that I think it is a pity to waste time considering whether the Surgeon General and the State and Territorial health officers can agree. There is only one science of administrative public health, and the contents are well-known. They are taught in our educational institutions of higher learning. There are no two kinds of health, and there can be no differences of opinion among people professionally responsible for health, as Dr. Getting has said.

I see no conceivable excuse for having recourse to the courts to settle a diffrence between such persons as the Surgeon General and the State and Territorial health officers.

I would ask you to remember this: That we have waited long for this. Priority, of necessity, points inevitably to the local health units as being more urgent than any other thing before you in the field of health legislation. It will cost less to do the other jobs that you will have in the future if you have a retail distribution point for public health provided for every unit of population and capable of covering, in the sanitary sense, every square mile of this country. We are entitled to it, and we look to you to help us get it.

I thank you.

Mr. WILSON. Dr. Emerson, the committee appreciates very much your well prepared statement and your manner of presentation of it. I speak for the committee in saying that we are mighty happy to have you before us.

Mr. Bennett, do you have some questions of Dr. Emerson?

Mr. BENNETT. I, too, appreciate the fine statement you have made, Doctor, and I recognize that you are one of the leading authorities on this subject in the country.

I have been wondering, as I have listened to the testimony this morning and so far this afternoon, about what you would think of the advisability of putting some language in the bill to define the scope of activities that this program is to cover. In other words, I mean the basic activities or the basic functions that this program is designed to cover, so that there will be some guideposts in the legislation by which the State departments of health can be governed in submitting their plans to the Surgeon General. Do you care to comment on that?

Dr. EMERSON. I can tell you this, sir: That every one of the States—their State health officers—have been asked what their State plan is, and they have presented that in a professional manner to the American Public Health Association. What they will present to the Surgeon General will be essentially the same thing. They will say for their particular State, whether it be Nevada or Massachusetts or whatever, that they recommend that there be so many local units of health administration in a particular State which will carry out such and such functions.

Now, they cannot recommend any basic health service without describing at least those that have been referred to here.

I believe, myself, that there would be no difficulty in expressing the desirable minimum basic services without indicating that no others in the future are to be added to them. It seems to me desirable to define those basic functions without which a health service is nothing but a name.

Mr. BENNETT. Will you name some, please?

Dr. EMERSON. There are the six that were named before. We can add a seventh which Dr. Getting referred to.

The first is the bookkeeping of public health, vital statistics. There must be some place where the bookkeeping of human life in a community is cared for, and that is vital statistics. That involves births, deaths, reportable diseases, demography, life expectancy, and the facts of life experience of that community. That is the first one. It is historical.

The second one is the control of communicable diseases. Now, if there is one thing in which we have triumphed it is in the control of communicable diseases, and we still have not finished that job. That includes syphilis, gonorrhea, malaria, tuberculosis, hookworm, and all of the acute communicable diseases of childhood.

Then the next is control of sanitary environment, the sanitation of environment. It includes the getting rid of the mosquito in the malaria areas and seeing to it that the water, the food, and the occupations are clean. Now, that is a full-time job for an engineer.

Then we have, as the fourth function that field, laboratory services. I think it was your own question this morning that indicated some counties—or was it the gentleman from Oklahoma—or some areas too sparse to justify a local health department. In that instance, they will contract with the State health department or with a hospital or otherwise to get those services. It does not mean that at every place they must have a special kind of laboratory, but laboratory diagnosis is the brains of a public-health program.

Then we have the two others which are of a voluntary nature, the guidance of maternity, infancy, and child health, those things upon which the replacement of our social community depends.

The last is health education, and I would include under health education practically all of the categorical topics that you have been assisting through Congress, mental hygiene, cancer, problems of rheumatism, nutrition, and heart disease, practically all of which are at the stage in which we must educate people rather than offer specific curative services.

Those things are the work of every health department worthy of the name all around the world. I do not know of anybody who pretends to operate a health department that does not have those services. Now, there are additions. There are enlargements of them. There are expansions of them. But those six services are, to my mind, the indispensable ones; and I see no reason why they should not be added.

There is great interest in the case of the aged, in the care of chronic diseases, diabetes, and others, and if it is desired to add those to the basic minimum, that is all right. I think perhaps those must wait a little while, but then there are States that are well advanced, as in Massachusetts, where they have developed an active program in that seventh field.

Mr. Bennett. Do you feel that the power given the Surgeon General under this bill, will satisfactorily carry out the programs to be submitted by the several States?

Dr. Emerson. I not only feel that, sir, but I recognize that the States relations division of the Public Health Service has been one of the greatest sources of information as to the present deficit and the necessary program for its correction. Without the Public Health Service and that division, it would have been very difficult for the State departments of health to discover the facts, as has been shown in these maps which depict the exact situation.

Mr. Bennett. Probably I did not make myself clear.

Under the bills that are proposed here, the Surgeon General has the final say. In fact, he has all of the say as to whether a particular plan submitted by a State will or will not be carried out. I understand that you approve of that method of handling the program.

Dr. EMERSON. I am afraid we are not talking exactly to the purpose. The program that the States will present to the Surgeon General is not a program of activity so much as a program of distribution of services.

For example, you have the State of Iowa. At present, about 4 percent of the people are now receiving the benefit of a full-time local health department. All the other 96 percent of them lack any reasonably defined local health service.

Now, if the Surgeon General says, "We have some money for Iowa, if Iowa will first give us an intelligent plan which provides for local health services for the entire State," they will give him a map, they will outline the areas, they will give an estimate of the populations concerned and the personnel needed, and it will be taken for granted in every instance that the services provided will be those as I have suggested to you. The program is not a program of work, but a program of distribution of local health units.

Mr. BENNETT. And in the case you referred to, of Iowa, if the State of Iowa submits its plan of the distribution of these funds in the areas within its own State, and the Surgeon General thinks that a different distribution should be made, you feel that he should have the authority rather than the State?

Dr. EMERSON. Yes; I think that is quite fair. There might be a difference of opinion. Let me just suggest this: When this was proposed on a national basis, we worked out 1,197 different local health units desirable and when we submitted that to the respective health officers of the States of these United States, they came back with 1,200. Now, the difference between our theoretical program and their individual State programs was a matter of nothing at all. Ultimately there would be approximately 1,200 such units of government necessary for local administration of health, and there was no question in any instance of the content of it, but simply what were the best practical ones.

I did not happen to know, for example, that there was a canyon that split one of the counties of Montana right through the middle and that you cannot get from one side to the other without using an airplane. So we made a little shift in our outline and took a fraction of one county and added it to the other.

There were similar conditions in Vermont and New Hampshire, where the laying out of the original counties did not lend itself to multicounty units. There will be differences of that kind. But I think you will find that they are of an insignificant kind.

The Surgeon General, with his States Relations Division, is in a position to agree to the dot with the local man who has the interest and competency of his own State at stake. I do not believe there is the slightest likelihood of any critical difference of opinion as to the services by States which are recommended by State health officers.

Mr. BENNETT. And if there are these differences of opinion, the Surgeon General should resolve them?

Dr. EMERSON. Of course he can. These men are highly responsible individuals seeking precisely the same thing you are in the bill. There cannot be any difference of opinion except whether I want two counties here or three counties there. That is going to be determined by the vote of the county commissioners.

Mr. BENNETT. Of course. I can see your attitude toward the problem. I respect your views. But there are two schools of thought around the country with respect to the initiation of programs of this kind, as to where the authority for the administration of the plan is going to be concentrated. That is, whether they are going to largely concentrate authority, whenever there is any Federal money involved, in a bureau or department here in Washington, or whether we are going to leave the States themselves, who are more closely connected, more closely concerned with the administration of the program, some authority on their own to administer it. That is the thing I am speaking of.

Dr. EMERSON. Yes, I understand.

Mr. BENNETT. That is, whether there should be a division of authority, or whether it should all be here in Washington.

Dr. EMERSON. We have recently held for 5-State conferences precisely on this point. We took the Rocky Mountain States, and we were there for 3 days considering what was the best method of extending local health services in this area. Representatives from each State came together at Salt Lake City for a conference to decide what was the best way, and they agreed together there, and there was represented at that conference the regional officer of the Public Health Service.

Now, when any proposal is made, they will have tried it out among their own people with regard to their own local communities, and they will come with a matured plan which is blueprinted and prepared for discussion. That is going on all over the country. As I say, we have covered more than half of the States already with this sort of a trial arrangement just the way the National Hospital Commission attempted to blueprint the application of the Hospital Survey and Construction Act by its proposals for hospitals.

Mr. BENNETT. Thank you, Doctor.

Mr. PRIEST. Dr. Emerson, we appreciate very much your appearance before the committee. As always, you have been very helpful.

Dr. EMERSON. Thank you, sir.

Mr. PRIEST. I want to state that it was necessary for Mr. Bennett to leave before Dr. Getting completed his statement, and I understand the gentleman from Michigan might have a question to ask of Dr. Getting?

Mr. BENNETT. Yes, sir.

Mr. PRIEST. Dr. Getting, will you return to the stand briefly?

Mr. BENNETT. Doctor, I gathered from your statement, I listened to it awhile ago, that you were satisfied that the Surgeon General should have the final say on whether or not the particular State program should be approved or disapproved?

STATEMENT OF DR. VLADO A. GETTING—Resumed

Dr. GETTING. That is entirely correct. Please understand my position, sir. I, as a State health officer, am responsible to the State government for the program which I operate, and not to the Public Health Service or to the Federal Government. Yet at the same time I have complete confidence in the ability of the Public Health Service to evaluate both professionally and administratively the plan which I submit.

As a matter of fact, plans have been submitted for tuberculosis, venereal diseases, and other programs since about 1935, when the Social Security Act, title VI went into effect. To my knowledge there has not been any categorical denial or turning over of a program at any time by the Public Health Service for any State. On occasion, the Public Health Service has made suggestions to the health officer who has asked for review of certain portions of his plan. Those reviews have always been terminated to the mutual satisfaction of both the Surgeon General and the State health officer.

Mr. BENNETT. Do not misunderstand me in my line of questioning, Doctor. I am not inferring that the Surgeon General in the administration of this program will arbitrarily discriminate against one State or another, or categorically or arbitrarily turn down a plan. The question that concerns me is whether he should have the right to do so, if either the present Surgeon General or one of his successors decided that he wanted to act in that manner.

In other words, should the law give him that authority?

Dr. GETTING. Yes; I do not think there is any question about it, because, after all, some administrator has to be made for the handling of the Federal funds on the Federal level and the logical person is the Surgeon General as the administrator, and I believe that he is responsible not only to Congress and to the Federal Security Administrator, but is morally and ethically responsible to the State Health Officers.

Mr. BENNETT. Under this bill, he would not only have the authority to control the money at the Federal level, but also have the authority to control it at the State level, because he has the authority to approve or disapprove of the plans that are submitted by the States. Hence, he can tell you, for example, as administrator of the State of Massachusetts, that what you have submitted for a certain county does not meet with his approval and therefore you must change it to suit his thinking. I mention that to say that what we are talking about is not control at the Federal level, but control by the Federal Government at the State level.

Dr. GETTING. There has never been any, shall we call it, transgression, on the part of the Public Health Service below the State level. Funds now do go to local health departments, and all transactions are held at the State and Federal levels; it is only upon the request of the State Health Officer that the representatives of the Federal agencies go into local levels.

Now, what you say is, in theory, possible; in practice, it is highly improbable.

We, for example, make funds available to the city of Boston, as we do to other communities in Massachusetts. Now, the Surgeon General has never denied the applicability of such funds, as they have been consistent with the regulations as determined by the Surgeon General and the State health officers. This is so because the plans are based upon those regulations.

Mr. BENNETT. And the Surgeon General makes the regulations?

Dr. GETTING. He establishes the regulations only after review and consultation with the State health officers, and in agreement with them, insofar as is practicable.

The amendment that is being recommended by the Acting Surgeon General indicates that those changes will not be more often than every

2 years, and that was our request. We did not want too many changes in regulations to occur too suddenly.

Mr. BENNETT. What I am thinking about is this: For example, I live in the Northern Peninsula of Michigan. Suppose the Michigan Health Commission submits a plan to do some work up there, and somebody down here in the Surgeon General's Office says "That is not feasible; you better start somewhere else in Michigan."

Right on that point, I think I would rather take the judgment of the State people who are right on the ground and know the situation than I would the judgment of somebody down here in the Surgeon General's Office who does the vetoing.

Dr. GETTING. The Surgeon General has never acted arbitrarily in that manner.

Mr. BENNETT. I am not saying he has.

Dr. GETTING. Nor is there any reason to believe that he would. Of course, it is impossible, as all lawyers tell me, to discuss a hypothetical case which has not occurred and is not likely to occur, because the details are not present.

I would say that if there were a difference of opinion between, let us say, me, as State health officer of Massachusetts, or between the State health officer in Michigan and the Public Health Service, the manner in which it would be handled would be similar to this:

The regional representative of the Public Health Service, who is the medical director, would call upon the State health officer and say to him, "Look, here is what you have outlined. I have carefully studied this and they have carefully studied it in Washington, and here is what they think. What is your reaction to this?"

Then after that discussion, he would then make a report back to the Public Health Service and the chances are that the report as he made it would be accepted, and I have never known it to be contrary to the plan as submitted.

Mr. BENNETT. I have not either. But the basic question here is not whether you have full confidence in any particular public official because they change from day to day and year to year. Some are good and some are not so good. But when you write this law, you are giving the same authority to a good man who will use the authority judiciously as you are to a man who might not use it as judiciously, so while you are perfectly satisfied with what has happened today, and you feel there is little likelihood of any abuse of discretion, still you cannot see into the future, and neither can I, as to what somebody else is going to do. So it gets back to whether the control is going to be entirely invested in the Federal level or whether some control is going to be given to the States. As I understand it, you feel the full control should be here in Washington?

Dr. GETTING. Insofar as the final approval is concerned, yes, because we feel that the Surgeon General will always be a highly professional person who is selected from the corps, and therefore, has had a great number of years of service, is usually an individual who has had experience either on the local level, the State level or both, and being a specialist in public health, he appreciates the problems of the local administrator.

It has been our experience that such a man would rarely hold a difference of opinion concerning priority items between one county and another.

Mr. Bennett. Doctor, in your statement you said something about limiting the authority of the Surgeon General on withholding payments.

Dr. Getting. Only if all the categorical grants were to be lumped into one single grant. We feel that if the Surgeon General be given blanket authority, he would then by regulation return to us exactly the same position, or even further, as we now have with simple categorical grants for each different activity.

We believe that if the amount of money which would be assigned by prescribed portions for heart disease or cancer could be limited, greater flexibility would be allowed the health officer in meeting the local needs.

Mr. Bennett. So you trust the Surgeon General on one phase, but not the other?

Dr. Getting. We trust him on that feature, also, but we feel, as you feel, that a State has a certain right to determine how the money shall be expended within its limits.

Mr. Bennett. If you are willing to let the Surgeon General approve the entire plan for the State, and you are completely satisfied with his judgment there, what makes you feel that he will not be fair and judicial when it comes to allocating the funds?

Dr. Getting. We feel that he probably would be judicial, but that an added safeguard can be placed, and that is the safeguard which we recommend.

Mr. Bennett. Why do you need a safeguard? If what you say about the trustworthiness and the ability of the Surgeon General is justifiable, why not give him the same authority to allocate the funds as you want to give him for approving the State plans?

Dr. Getting. Perhaps some of us, being from New England, are conservative. For instance, some of us wear both a belt and suspenders. We do not need both, but we believe in playing safe. But in this instance it becomes an added safeguard to have limitations concerning those regulations.

Mr. Wilson. Both of those precautions, the belt and the suspenders, have the same objective, do they not?

Dr. Getting. Yes, sir.

Mr. Bennett. Mr. Chairman, I believe that is all.

Mr. Wilson. Doctor, in your statement you spoke about the definition of basic local health services as adopted by the National Health Assembly in May of last year.

Dr. Getting. Yes, sir.

Mr. Wilson. I notice that it encompasses seven rather than six.

Dr. Getting. That is correct.

Mr. Wilson. That additional one is chronic diseases?

Dr. Getting. That is correct. It is chronic diseases, and I believe in preparing the report the committee had six, but it included chronic diseases as one of the six. It is one example of why it would be, in our opinion, contrary to public interest to define in the law the functions which a local health department should undertake. In some parts of the country as, for example, Massachusetts, there are many more older people than in Nevada. We are, therefore, more concerned with keeping them off the welfare load than they are in Nevada. To keep this population group both well and self-sustaining is a major issue with us right now, so we are engaged in a program of helping our older citizens maintain their good health.

Mr. WILSON. Your thought in defining it, if it was in the law, would be as inclusive but not all-inclusive; is that correct?

Dr. GETTING. That is correct.

The definition of basic local health services should be so stated that it will not prohibit the expansion of public health as we acquire new scientific knowledge.

Mr. PRIEST. Are there any other questions? If not, thank you very much, Dr. Getting.

Dr. GETTING. Thank you, Mr. Chairman and gentlemen of the committee.

Mr. PRIEST. The next witness is Mr. H. B. Anderson, secretary of the Citizens Medical Reference Bureau, Inc., of New York City.

STATEMENT OF H. B. ANDERSON, SECRETARY OF THE CITIZENS MEDICAL REFERENCE BUREAU, INC., NEW YORK, N. Y.

Mr. ANDERSON. Mr. Chairman and gentlemen of the committee, we have filed with the committee a general statement protesting against the passage of the bills H. R. 4312 and H. R. 4313, and requesting an opportunity to appear in person in opposition to title V of these bills.

We particularly protest against the passage of title V, because if the Public Health Service is permitted by regulation to determine the scope and activity of all local public-health units in the United States it would then be provided with the most powerful machinery it would be possible for any Government agency to obtain, with which to secure the passage of any legislative program in the States or Nation it desired for the regimentation of the individual from the cradle to the grave.

However, I wish to make it clear at the outset that I am not here to protest against the establishment of local health units, as such. My protest is directed entirely against delegating power to the Public Health Service to regulate the scope and activities of local public-health units.

I particularly refer to sections 315, 316, 317, 318, and 319 as providing for centralized Federal control of all local public-health units.

Some idea of the power with which the Public Health Service would be provided if it were granted authority to regulate the scope and activities of all local public health units may be gained from the fact that under the terms of the bill, local public health units are concerned with "the prevention, treatment, and control of diseases." And I respectfully submit that a Nation-wide program centralized in Washington for the "prevention, treatment, and control" of all diseases is so all-inclusive that it embraces all clinics and hospitals, all medical schools, all medical practice, all branches of the healing art, economics, housing, sanitary engineering, sociology, and even touches upon the problem of religion. In fact the term "public health" is so broad in scope that any ideology the experts in charge of this machinery might wish to promote could be foisted upon the American public in the name of health.

In his report, The Nation's Health—A 10-Year Program, Oscar R. Ewing, Federal Security Administrator, estimates that the public-health program in 1960 will cost $4,107,000,000 of which $2,312,000-

000 is to be supplied by the Federal Government and $1,795,000,000 is to be supplied by the States. This is in addition to the $6,000,000,000 or more annually to be supplied for a national system of health insurance. You have only to compare the $4,000,000,000 annually to be under the control of the Federal Security Administrator and his conferees to the comparatively few millions of dollars contributed periodically to political campaigns, to realize the enormity of the propaganda machinery which the Federal Security Administrator would have at his disposal if this bill were allowed to pass.

The answer to this problem would seem to be to let the States collect a larger share of the taxes as proposed at the recent Governors' Conference at Colorado Springs, and thereby eliminate the necessity for more and more Federal aid to the States.

Federal grants to the States amount to approximately $2,000,000,000 a year, and there is today a strong sentiment in favor of reducing these grants by 20 percent instead of increasing them, as proposed in this bill. In 1900 only 8 percent of the national income went for taxes. In 1948, 30·3 percent went for taxes. The passage of this bill would mean a still further skyrocketing of taxes.

The combination of a Nation-wide system of compulsory health insurance with a public-health program as provided in this bill is particularly objectionable to large numbers of persons, because of its bearing upon fear campaigns and compulsory medication.

We are all desirous of seeing illness and fatalities in the United States reduced to the minimum, but there is a wide difference of opinion as to the best method for accomplishing this result.

When Congress appropriates $10,000,000 annually or $100,000,000 annually to the Public Health Service for the alleged prevention of tuberculosis or some other disease, it does not necessarily mean that the death rate from this particular disease will be correspondingly reduced. What it means is that the Congress will become saturated with propaganda in favor of some new vaccine or serum or the people will be told to be examined. In other words, the entire Nation will become disease conscious and many of the highest medical authorities point out that fear may be the means of actually causing disease.

Some idea of the extent of these "scare" campaigns may be gained from the statement in an editorial in the Journal of the American Medical Association, December 13, 1947, that—

> About 45,000,000 pieces of literature prepared by the American Cancer Society, during the last year carried the seven danger signs of cancer * * *.
>
> The fear of cancer may come to be recognized as a psychosomatic factor in the actual inception of the disease itself—

according to J. J. Lightbody, M. D., in an editorial entitled "Cancerphobia—True or False," published in the Detroit Medical News, September 17, 1945.

> "It is controversial" says Dr. Lightbody, "whether knowledge concerning the early symptoms of heart disease would decrease the deaths due to organic heart disease because as soon as a person becomes cardiac-conscious, his symptoms are usually accelerated. Precancerous conditions would tend to act the same way."

Dr. James F. Brailsford, Britain's most noted radiologist, has been widely quoted in the American press as saying:

> If you feel fit and well, stay away from all doctors. Even in the case of cancer, nature will notify educated persons when to seek medical advice. Mass X-ray

examinations for tuberculosis and cancer do more harm than good. Periodic examination of those who have no symptoms of tuberculosis and cancer are of doubtful value.

Fear campaigns are directly related to the propaganda for compulsory medication because if the Public Health Service is to be provided with billions upon billions of dollars which it is permitted to use for propaganda purposes, it would be in a position to exploit and make compulsory any vaccine, serum, or other medical procedure it chose for the alleged cure or prevention of disease.

In England the vaccination laws from 1867 to 1907 have all been repealed, but in the United States the Public Health Service goes out of its way to require vaccination of all passengers entering the United States from foreign countries, whether any cases of smallpox have been reported from the ports of embarkation or not. This stretching of the quarantine powers granted by Congress to that service for use in time of actual emergency is highly questionable.

Just how I feel on this question of compulsory vaccination is clearly outlined in a book I wrote 20 years ago, The Facts Against Compulsory Vaccination.

Now, a statement recently made by a former Secretary of State, James F. Byrnes, is very much in line with our viewpoint.

In developing his criticism of a welfare state, Mr. Byrnes said:

> We do not want the Federal Government regimenting our lives from the cradle to the grave. The Government is now taking tax money for welfare and social agencies from the States although it could be put to better advantage by remaining in the individual States."

Now, so far as I am concerned personally, I happen to be a native of the State of Iowa. It has been stated here that the State of Iowa only has about 4 percent of its units on a full-time basis.

I submit that if the State of Iawo has not adopted these full-time health units, that it is not because Iowa has not got the money to do it with; it is simply a case that you have not sold the idea to the State of Iowa that it should adopt these health units.

The same would be true of a great many other States. In fact, maybe about 30 years ago or something like that, they decided to make a health demonstration in Cattarragus County in New York, and they spent so much money in that county the people were actually disgusted. Even the medical profession to a large extent was disgusted. I believe that had a great deal to do with holding back the establishment of health units in the State of New York.

As I say, I am not against local health units. It is simply that I do not like this whole system where every year the Public Health Service is working up perhaps 20 or 30 bills trying to get more and more power over everybody. If you examine some of the addresses made by Dr. Parran in 1944, and so forth, it is almost like he wanted a military system in the whole United States.

It is copied after the Army system. The people do not want that in civilian life.

I thank you very much, Mr. Chairman.

Mr. PRIEST. Thank you, Mr. Anderson. We appreciate your testimony before the committee.

Mr. ANDERSON. Thank you.

Mr. PRIEST. Our next witness will be Dr. Edwin L. Crosby, vice president of the American Hospital Association and Director of the Johns Hopkins Hospital, Baltimore, Maryland.

STATEMENT OF DR. EDWIN L. CROSBY, DIRECTOR OF THE JOHNS HOPKINS HOSPITAL, BALTIMORE, MD., AND FIRST VICE PRESIDENT OF THE AMERICAN HOSPITAL ASSOCIATION

Dr. Crosby. Mr. Chairman and members of the committee, I appreciate this opportunity to appear before your committee to discuss these bills.

I should like to state at the outset that I appear as the first vice president of the American Hospital Association. I have a special interest in the relation of hospital and public health activities as I am present director of the Johns Hopkins Hospital in Baltimore and adjunct professor, public health administration at the Johns Hopkins University School of Hygiene and Public Health, where I received the degree of doctor of public health.

With the committee's permission, I would like to append to this statement two documents which I believe are especially germane to the subject under discussion.

The first is a joint statement of the American Hospital Association and the American Public Health Association on Coordination of Hospitals and Health Departments which has been adopted as an official statement of the two associations.

The second is a paper on The Training of Health Manpower, presented by Dr. Lowell J. Reed, vice president of the Johns Hopkins University, at the seventy-sixth annual meeting of the American Public Health Association, on November 9, 1948.

I should like your permission to append those two statements to my prepared statement.

Mr. Priest. Very well, you have my permission, and they will be incorporated in the record.

(The statements have been placed in the committee files.)

Dr. Crosby. The interest of the hospital association and of hospital officials in supporting this legislation, which would assist in the maintenance and extension of local public health services, stems from a change in the concept of medical care.

Traditionally, public health departments have been primarily concerned with the prevention of infectious diseases. Their success has been notable. Their work in the field of sanitary engineering has been largely responsible for the amazing drop in the incidence of typhoid fever. It was necessary to carry on a recent therapeutic trial of a new drug outside of the United States due to the lack of typhoid fever cases here. The success of the public health immunization program is shown by the dramatically reduced morbidity rates in smallpox and diphtheria.

The hospital, on the other hand, has long been regarded as the headquarters of curative medicine, the arsenal where new weapons against disease are forged and where physicians find readily at hand every conceivable tool to forestall death and to hasten the patient's return to health.

Historically, public health facilities and hospitals have developed separately. Today, however, it is realized that they are interdependent. They have a community of interest in the whole problem of medical care. Preventive medicine and curative medicine must go hand in hand in planning, training, and utilization, if we are to get an optimum return from our over-all medical care program, if we are to make the best use of our medical resources.

As the joint statement of the American Hospital Association and the American Public Health Association, to which I have referred, says:

> Preventive and curative medicine have reached the stage where they are no longer separable and it is necessary at the present time to bring them together physcically and functionally. The close physical and organizational association of health departments and hospitals will provide a valuable step toward this essential goal.

Nowhere is this need greater than in our rural communities. It should be realized that almost all of this Nation's general hospitals are small hospitals, serving small communities. For instance, approximately 1,000 have fewer than 25 beds, another 1,000 have between 25 and 49; 1,000 have between 50 and 99; 800 have between 100 and 199; and only about 700 have more than 200 beds.

In other words, two-thirds of the hospitals are less than 100 beds in size.

The joint statement of the American Hospital Association and the American Public Health Association continues:

> Hospitals and health departments have a common interest in providing the best possible technical facilities and administrative tools for the further development of both the preventive and therapeutic aspects of medical practice. The expression of this relationship in terms of greater coordination of the activities of hospitals and health departments has already occurred in some communities, but a great deal still remains to be accomplished in this direction.

When there is no public-health unit in a community or in an area, the hospital cannot function as effectively as it should. The converse of this statement is equally true. Therefore, it seems eminently sensible and practical to work for the extension of hospital facilities as provided in the Hill-Burton Act, Public Law 725, for the extension of basic public-health units, as provided in the bills now under discussion, and for their integration.

The local health unit and hospital will, particularly in the smaller community, emerge as a true community health center as more effective medical-care programs develop. In such a case the public-health officer should be hospital officer as well, thus becoming a health officer in the full meaning of the word. In various sections of the country, such a practice is already established. In Branch and Barry Counties of Michigan, the health officer has been responsible at times in recent years for both the local health department and the hospital. This has been found to be a better form of administration for these units and provides more efficient operation and integration of their activities.

In the State of Arkansas space is being provided for the local health department in all of the rural hospitals being constructed under the provision of Public Law 725.

The Commission on Hospital Care, as Dr. Emerson has already explained, said, and I quote:

> Hospitals and health departments should coordinate their efforts and integrate their functions. There should be close relationship between hospital and public-health department programs, so that the educational activities of the hospitals can include training in public-health work. Unnecessary duplication of effort and equipment should be avoided whenever possible through joint use of facilities by hospitals and public-health departments. Integrated action pro-

> grams, involving laboratory tests, X-ray examinations, case-finding activities, maternal and child clinics, outpatient services, and communicable disease control, should be conducted jointly by hospitals and public-health departments. Cooperative programs of health education, preventive medicine, visiting nurse service, social service, and statistical reporting between hospitals and public health departments should be extended.

Increasingly, public health education is including training in hospital administration. Private philanthropy, especially the Kellogg Foundation, has been of material help in this work. The foundation supports courses at Johns Hopkins and elsewhere to train the public health officer in hospital administration and the administrator in public health, and thus equip them more completely for their larger duties of the future.

These bills would have their greatest immediate impact on rural areas, where the need for health work is most urgent, but they would also affect our largest urban medical centers by making possible the extension of their services to even the isolated rural communities. However, one must not lose sight of the needs of the teaching medical centers where the training for these efforts is accomplished.

We already have evidence of the effectiveness of a program to link the small area to the large teaching centers through a regionalization of services and training. This is certainly not going to attain maximum effectiveness if the rural community is missing either hospital or public health unit. It must have both. It is not going to be done as well as it should or as promptly as it must be if the States and local communities do not receive financial aid in determining the best form for this pattern to take and act in the actual establishment of these units.

A hospital is no longer a structure with defined boundaries. A public health unit is no longer just a headquarters for immunizations, sanitation control, and venereal disease prophylaxis. They are a health center, inextricably bound together, devoted to keeping and getting people well.

Appreciating the interdependence of the hospital and the public health unit, the American Hospital Association endorses additional grants for public health, as outlined in these bills.

I, personally, hope your committee and the Congress act favorably upon this legislation.

Mr. Priest. Thank you very much, Doctor. This statement of yours presents to the committee a phase of the legislation that perhaps we had not considered prior to your statement. That is, the close interrelationship between the public health service and the hospitals. Personally I think you made a very good case for such relationship.

Are there other questions?

Mr. Wilson?

Mr. Wilson. Doctor, I believe the American Hospital Association previously appeared before the committee?

Dr. Crosby. Yes, sir.

Mr. Wilson. I believe they appeared with relation to survey and construction of hospitals. In that respect, they have advocated and endorsed the program of the extension of the percentage of Federal grant-in-aid to construction to increase it from a third to 40 percent.

Dr. Crosby. Yes, sir.

Mr. Wilson. Is it your personal opinion that it is sound to increase the paternalistic benefits in the form of money and finances to the local community so that it can intertwine the hospital and the public-health service?

Dr. Crosby. If I understand your question correctly, and I think I do—yes. I object to the word "paternalistic."

Mr. Wilson. You shied away a bit from the word "paternalistic."

Dr. Crosby. Yes, sir.

Mr. Wilson. You state here on page 3 of your statement—

> When there is no public-health unit in a community or an area, the hospital cannot function as effectively as it should.

That, to my mind, has a lot of meaning. Would you give your one, two, three reasons why that is so?

Dr. Crosby. The health officer is an important medical person in any community, and if there is no health department and no local health officer in a local county, the hospital administrator and the medical staff of the hospital are expected not only to take care of the patients and to get them well but also to assume the role of the local health officer in sanitation, well baby clinics, and so forth. They need the guidance and supervision of a well-trained local health officer in administering the health problems of the population.

Mr. Wilson. Because of the importance and the connection with the program?

Dr. Crosby. That is right. The health officer serves the entire population. The hospital itself serves only 10 percent of the population, because only 10 percent of the population is hospitalized each year. They do not have the facilities for getting outside of their brick walls to do what the visiting nurse should do, to get out in the rural areas, as Mr. Priest mentioned. You do not have a sanitation officer, and so forth.

Mr. Wilson. As that grows, are they not encroaching more and more on the field of the private practitioner?

Dr. Crosby. Not in the realm of preventive medicine. If you have the happy marriage of the hospital staff and the local-health department, you are not encroaching upon the practice of medicine as practiced by the local practitioner. I mentioned Branch County in Michigan. I was very much impressed when I went there about 2 years ago to see how much more effective the program of the local health officer was when he was made the hospital administrator and was responsible for the medical staff. He had been unsuccessful in doing such things as promoting a diphtheria immunization program for the 25,000 population in Branch County, but as soon as he became the hospital administrator the operations, with his medical staff, were improved 1,000 percent, if such a thing is possible; at least they were improved tremendously. I point out that was effective economically, as well as efficiently, because one position was done away with. He was to be administrator of the health department as well as the hospital and was responsible to the local board of trustees for the operation of the hospital.

Mr. Wilson. As that program advances, intertwining the management of the hospital together with the operation of the public health, will it include encroaching upon the private domain of private hospitals, such as those operated by various orders, and by community hospitals?

Dr. Crosby. No; I do not think it should. This hospital in Branch County was a community hospital. It was the only hospital for the county. I do not know how the Catholic Hospital Association would operate in such a situation. I talked to them about this particular problem at the Catholic hospital meeting in St. Louis 2 or 3 weeks ago, and they were very much intrigued with the idea of the service which the Catholic hospitals themselves could render by cooperating and looking outside of their four brick walls as far as the care of patients is concerned; that is, keeping them well, as well as getting them well.

Mr. Wilson. You know, in the years gone by that the doctor himself, perhaps through necessity, had to start operating a hospital—one of these hospitals that you described—25 beds or under, or 100 beds or under.

Dr. Crosby. That is right.

Mr. Wilson. We do not see that so much now.

Dr. Crosby. We do not see it as much in the East. There are still quite a number of the so-called proprietary hospitals in the Midwest. I think they are becoming a decreasing proportion.

Mr. Wilson. Why is it becoming decreasing in proportion. Is it less attractive for the doctor, or is it the removal of a burden that he does not want?

Dr. Crosby. He gets rid of a burden he does not want, he can turn the responsibility over to somebody else and, what is more, the whole community of doctors can be served better by one hospital than each doctor being served by an individual proprietary hospital. It is not efficient to operate a hospital of 10 or 15 beds; it gets to be more of a convalescent home. Folks feel that it is not efficient to operate a hospital of less than 50 beds because you cannot provide the necessary overhead and ancillary facilities such as laboratories, X-rays, and so forth, to do a good job in a hospital. I say that in spite of the fact that I have given you figures that show that almost 50 percent of the hospitals in this country have less than 50 beds right now.

Mr. Wilson. It seems to me that you have something there. However, the overhead and operation of a hospital and the reluctance to assume the responsibility to carry forward and maintain it and operate it, it seems to me as though it is one of the millstones hanging around the neck of the people and maybe if the Government took over the management and operation of the hospitals maybe that is the answer; and maybe the answer lies in the manner you say, in the Public Health Service man being the administrator of the hospital.

Dr. Crosby. I think that is one answer that we have been experimenting with and it may be effective. I have seen it operating so as to be helpful to have the health officer running not only the health department, but the hospital. It is not only more efficient, but you have better integration of your public-health nurse with the in-patient service of your hospital so that when your patient goes home the nurse can take care of the family at home, and so forth.

Mr. Wilson. This public health service man would be one who got his salary, his livelihood, from public funds?

Dr. Crosby. That does not necessarily follow. At Branch County, one of the reasons they were able so successfully to operate this thing was that the private funds of the hospital supplemented the government funds of the county commissioners or whatever they have in

Michigan so that they were able to pay him sufficiently to keep him in Branch County. The salary for the local health officer as such was not good enough to hold him and he was going to more lucrative fields.

But, by reason of what they were able to add to that, they were able to hold a good man so that he could be both the health officer and the hospital administrator. He had difficulty with the accounts receivable getting out of bounds but it did not take him long to find a good bookkeeper who could tell him what to do. Then he was able to control an epidemic of diarrhea in the nursery where his public-health work stood him in good stead.

Mr. Priest. Thank you, Doctor.

Are there any further questions? Doctor, we thank you very much for your statement.

Dr. Crosby. Thank you, gentlemen.

Mr. Priest. Our next witness will be Mr. James G. Stone, Director of Program Development of the National Tuberculosis Association.

May the Chair inquire, before Mr. Stone proceeds, if Dr. Lloyd C. Halvorson is in the room?

STATEMENT OF JAMES G. STONE, DIRECTOR, PROGRAM DEVELOPMENT, NATIONAL TUBERCULOSIS ASSOCIATION, NEW YORK, N. Y.

Mr. Priest. You may proceed, Mr. Stone.

Mr. Stone. Mr. Chairman and members of the committee, I am James G. Stone, director of program development of the National Tuberculosis Association.

With your permission I might very briefly abstract this statement in view of the fact that you have already had many witnesses who have discussed the technical aspects of the bill.

The board of directors of the National Tuberculosis Association has reaffirmed its long policy favoring the establishment of local health units and has also approved in principle Federal grants-in-aid as assistance to States to complete the coverage of their respective populations and areas with full-time local health units under professional direction.

I might point out that the National Tuberculosis Association is a federation of some 3,000 State and local associations, each one of which is controlled by a board of directors of local citizens, private practitioners of medicine, doctors, lawyers, and merchants and so forth in the community. The board of the national association is composed of representatives from the State and local groups. I might point out further in this connection too, that the mandate for the national action came as a grass roots growth from the people in the local areas throughout the country. That has come because of their belief that they cannot do an effective job of tuberculosis control without the full-time effective services of qualified local health units within their areas.

In our opinion, the bills, H. R. 267 and the companion piece in the Senate, S. 522, most effectively embodies the principles which should be carried out to gain the most speedy possible coverage of full-time health services for the country.

Mr. PRIEST. Thank you very much.

Are there any questions, Mr. Wilson?

Mr. WILSON. No questions.

Mr. PRIEST. We thank you so much for your statement. Without objection there will be incorporated in the record at this point a statement from Dr. Lloyd C. Halvorson, economist of the National Grange on the pending legislation.

(The statement is as follows:)

STATEMENT OF LLOYD C. HALVORSON, ECONOMIST THE NATIONAL GRANGE

In 1947 the National Grange took the following action in regard to local public health departments:

"1. A third of the population of the United States particularly in rural areas is without an organized local health department directed by a full-time health officer.

"2. Twenty-thousand of 38,000 different local governmental jurisdictions and 70,000 of 108,000 school districts are each attempting to operate their own health services.

"3. Such small units of government cannot expect to have enough tax money to attract the necessary trained workers to carry out a public health service to which the people are entitled. Therefore be it

Resolved, That we favor:

"1. The enactment of State laws authorizing the creation of county-wide, city-county, or multicounty units of health jurisdiction.

"2. The employment of professionally qualified full-time health officers at appropriate salaries.

"3. Requirement by law that health departments carry on certain essential standard activities; and also

"1. Many rural counties are too small to be able to support a well-equipped and adequately staffed health unit.

"Recommendation: State legislatures may need to pass a law enabling the establishment of county, city-county and multicounty health units which would be large enough to hire full-time personnel.

"2. Many rural communities do not have the protection and services of a public-health unit.

Recommendation: Rural people should seek to establish for their communities adequate public-health services. The annual costs would be somewhat in excess of $1 per person under present conditions.

"3. Some communities cannot afford public-health services, and this may be a hazard to other communities.

Recommendation: Already the Federal and State Governments are providing rural counties with financial aid, but some expansion in the aid may be needed to do an adequate job. The National Grange should support legislation to meet this need.

"4. Preventing the spread of disease is still a major aspect of public health. However, with the increase of degenerative diseases, preventive medicine may need to give more emphasis to detection of these diseases.

"Recommendation: Laboratory tests and X-rays probably should be made a public-health function. Increased Federal and State aid may be needed to enable local communities to do this. Legislation to achieve this should be supported."

These actions were reaffirmed by the National Grange session at its last annual session (November 1948).

Farm people are becoming increasingly aware of the need for public-health services. They have learned that the large congested cities, where diseases at one time took a heavy toll, have now about conquered the communicable diseases. They are shocked to learn that the communicable and preventable diseases are taking a higher toll in the country than in the city. They see how a good public health department can help guard the health and lives of children and mothers in the community; they are concerned with sanitation in parks, public eating places, the community generally; and they are becoming increasingly concerned with good water and sewage disposal in their own homes. They want to stamp out certain diseases; they want a good quarantine system; they want immunization programs; they want education and they want somebody fighting disease and ready to stop outbreaks of disease whenever and wherever it occurs.

Public health services has long been recognized as a type of function that naturally falls upon government and as a highly desirable form of service that will safeguard the health of all. We believe that responsibility for public-health service is primarily a matter for local government, but we also recognize that disease knows no boundaries and that the State and Federal Governments have some responsibility. Unfortunately some local areas and States do not have enough resources to fully meet their responsibility to the public health. For this reason we favor a grant-in-aid program to overcome the financial obstacle. As far as the Federal grant-in-aid program is concerned, we believe it quite appropriate that the States be required to match every Federal dollar with $2 on the average, but with variation among the States according to resource and need.

We hope that this Congress will pass a bill providing for grants-in-aid for expanded public health services and more and better local public-health units.

Mr. Priest. Without objection, we will insert in the record at this point the letter from the American Heart Association, Inc.

(The statement is as follows:)

American Heart Association, Inc.,
New York 19, June 28, 1949.

Mr. Robert Crosser,
Chairman, Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D. C.

Dear Mr. Crosser: I regret that previous commitments will prevent my attending the meeting of the Subcommittee on Public Health, Science, and Commerce of the Committee on Interstate and Foreign Commerce at 10 a. m. on July 6, 1949.

However, I thought you might like to have for presentation to this subcommittee copy of the attached resolution which was adopted by the board of directors of the American Heart Association on March 8, 1949. I am also sending a copy of this letter and resolution to Mr. J. Percy Priest, chairman of the subcommittee.

Your interest in constructive health legislation is deeply appreciated.

Sincerely yours,

John W. Ferree, M. D.,
Director of Public Health.

The board of directors of the American Heart Association is keenly aware of the necessity for complete coverage of the Nation with full-time local health departments so staffed and financed that they may render the basic public health services commonly accepted as the right of all citizens. With knowledge of the present deficiencies in the quantity, quality, and distribution of such services, the board urges its membership and its affiliate bodies to initiate and give support to all appropriate measures that will obtain for their communities competent health departments.

The board further recognizes the need for financial assistance to many local communities for providing the services and facilities they require and so, to assure a strong Nation-wide public health structure, approves in principle Federal legislation designed to make such financial assistance available.

The American Heart Association is in full accord with the program of the National Health Council and its national advisory committee on local health units for joining together in cooperative action the professional and lay forces to gain the desirable objective of adequate full-time local health services for all people.

Mr. Priest. Next we have a letter and a statement from the National Foundation for Infantile Paralysis, Inc.

(The letter and statement are as follows:)

The National Foundation for Infantile Paralysis, Inc.,
New York 5, N. Y., June 30, 1949.

Elton J. Layton,
Clerk, Congress of the United States, House of Representatives,
Committee on Interstate and Foreign Commerce,
House Office Building, Washington, D. C.

Dear Mr. Layton: Your notice of the hearings to be held on local public units bills, H. R. 267 and H. R. 785, arrived in Dr. Landauer's absence from the city.

Dr. Landauer has a previous commitment for July 6, so that I do not believe it will be possible for him to appear before your committee.

I am enclosing five copies of the statement presented by Dr. Landauer when he appeared before the Senate committee in favor of these same bills. I believe that his testimony would be the same were he able to appear before the House committee.

Sincerely yours,

VIOLA KANTOR,
Secretary to K. S. Landauer, M. D.

STATEMENT PRESENTED BEFORE THE CONGRESSIONAL COMMITTEE ON LOCAL HEALTH UNITS

The National Foundation for Infantile Paralysis wishes to advise the Special Subcommittee on Local Health Units of the Senate Committee on Labor and Public Welfare, holding hearings on S. 522, proposed nonpartisan legislation sponsored by the National Congress of Parents and Teachers to provide Federal financial aid to states to improve and extend local public health services, that it endorses this bill and urges that such legislation be enacted.

The national foundation believes that such legislation is needed to extend the provision of the six basic and essential public health services to the 40,000,000 of our people who now lack these entirely and to strengthen and expand these services to another 85,000,000 of our people who are now only partially or incompletely served. These services are vital statistics, control of communicable disease, environmental sanitation, maternal and infant and child hygiene, laboratory service, and health education. These are considered by the United States Public Health Service and the American Public Health Association to be the minimum services of a full-time professionally directed local health unit.

The National Foundation for Infantile Paralysis, a national voluntary health agency, with chapters manned by volunteers in virtually every county in the country, is concerned primarily with one great health problem, poliomyelitis, a threat to every individual and community in the Nation. Epidemics of poliomyelitis continue to scourge our people and those of every country in the world with their disastrous effects. In combating poliomyelitis alone, which is but one of our serious national health problems, every one of these six basic public health services provided by a full-time local health unit is essential.

Mr. Basil O'Connor, president of the National Foundation for Infantile Paralysis and of the American Red Cross, recently expressed the views of the National Foundation for Infantile Paralysis in an address to the National Health Council on America's potential for health. He said, "At this moment there are about 40,000,000 American living in communities that lack the basic protection provided by a public health department as an essential Government function—40,000,000 of our people do not have access to adequate public health service. Probably not more than 10,000,000 people in the entire United States reside in areas having local health departments that meet minimal standards of well-trained personnel, adequate finances, modern equipment and efficient service.

"We of the voluntary agencies have tried to fill in the gaps as we encounter them. We have often been forced to overextend ourselves to provide services that normally should be the responsibility of a local health unit. I feel quite sure that all our health programs will be accelerated if, by the promotion of the National Health Council's objective, we can be instrumental in establishing well-staffed full-time local health departments in those places where they can best serve the greatest number of people."

The National Foundation believes that the first steps toward the protection, conservation, and improvement of our Nation's health must logically begin with the correction of these deficiencies. To reduce disease and protect health is to reduce the need and cost of curative medical care. The effectiveness and efficiency of the National Foundation's fight against poliomyelitis would be multiplied many times were good local public health services everywhere available.

The National Foundation believes that this noncontroversial, unanimously supported legislation deserves your committee's favorable consideration.

Mr. PRIEST. We will also insert in the record at this point a statement which the committee will receive tomorrow from Mrs. Jack B. Fahy, executive director, American Parents Committee on this legislation, and also two separate statements from the National Congress of Parents and Teachers.

(The statements are as follows:)

THE AMERICAN PARENTS COMMITTEE, INC.,
New York, N. Y., July 5, 1949.

Hon. J. PERCY PRIEST,
Congressman from Tennessee,
House of Representatives, Washington, D. C.

DEAR CONGRESSMAN PRIEST: In urging passage of the local public health units bills (H. R. 267 and H. R. 785), we would like to point out its direct effect on the well-being of America's children.

The American Parents Committee is a nonprofit, educational organization working toward improvement of the welfare of children. It is headed by Mr. George J. Hecht, publisher of Parents Magazine.

Of the Nation's 146,000,000 population, only 10,000,000 are covered by adequate public health service at the present time. A goodly percentage of the Nation's 45,000,000 children are among those not properly protected.

Without a local public health unit there is no assurance of safe drinking water. Pollution in unprotected communities can work faster in spreading disease than any kind of medical treatment to cure it. Milk, which is a basic food requirement of all children, can do infinitely more harm than good if it is not guarded against impurities by qualified inspectors. Epidemics can run rampant unless an immediate check is made and action taken to eliminate the cause.

Until you have a local public health unit, which includes a health officer, nurses for home calls during and after an illness, a sanitary engineer for water and sewage inspection, attempts at corrective health measures cannot be effectively carried out.

Plans are now moving forward in the field of child health which give promise for the future that America's children can become the healthiest in the world. Legislation to provide special health measures for children is becoming increasingly more important and favorable action in Congress is a progressive step toward a future healthier country.

Without the basic health program provided by local public health units, these programs cannot effectively be carried out. To superimpose a special health program when there is no basic program just doesn't add up.

Dr. Arthur J. Lesser of the Children's Bureau recently pointed out that in a nearby State which he had visited recently there are instances where the school privy is draining into the well which supplies the school's drinking water. No amount of preventive medicine can overcome a handicap such as this. There are no public health officers in areas where these things happen—no public health units established.

Home nurses, provided through local public health units, can mean the success or failure in the recuperation of a crippled child. One of the biggest obstacles in this instance is dealing with parents following the return of a child from hospital treatment. Special exercises are often called for, special care for a child in a cast, in order to assure his recovery. This is one of the many duties of the home nurse to assist the parents in seeing the program carried through.

Instruction in health education, provided by home nurses, can prevent some illnesses from occurring. Home accidents, a goodly proportion of which happen to children, can be avoided by simple instructions to parents.

Funds appropriated for special health services to children are being drained off to set up basic health programs. Nearby Anne Arundel County is a good example of this. Children's Bureau funds, earmarked for maternal and child health are necessarily being drawn off to carry out the work of local public health units, without which the program in this county could not be successful. At the present time there are eight public health units in Anne Arundal County. Services under the program include clinical service to local physicians, specialized pediatric service for prematurely born infants, pediatric consultations for the general practitioner, many of whom have had no specialized training in children's diseases.

Dr. William French, head of the program in Anne Arundel County, has arranged child health conferences, open to every child in the community. Eminent specialists are brought in from Johns Hopkins to consult on complex cases. Maternity cases needing special care are transported with public health funds to hospitals equipped to handle them.

Anne Arundel County has a proportionately high rural and Negro population with a resultant low per capita income. As is always true in lower income groups, many babies were born without medical assistance, and the infant and mortality death rates were high.

Since the establishment of adequate public health units, however, infant and maternal mortality rates in this county compare favorably with those of large eastern cities.

Funds to build these health centers in this county were raised by the people of the community. Community organizations and citizens purchased large homes throughout the county and converted them, with their own funds, into modern health centers.

Services of local physicans are used in the health centers and, in hardship cases, are paid for with public health funds, with complete cooperation between the health units and local physicians.

Response to appeals for funds for sick children is usually generous. But the job of keeping children healthy, under the well-child program of the Public Health Service is more difficult to dramatize. Yet, it is the basic protection against so many illnesses—the underpinning of good health. Good health habits begin with the child. The local public health officer is in a position to influence these habits through home nurses, education, arousing and stimulating community interest in local health programs.

Local public health units are essential to insure the effective carrying out of the many health measures affecting children now up for consideration before Congress. Local communities need the group services of the public health unit—to insure the effectiveness of any special health program.

Respectfully yours,

Mrs. JACK B. FAHY,
Executive Director.

STATEMENT BY MRS. ROLLIN BROWN, CHAIRMAN OF COMMITTEE ON LEGISLATION, NATIONAL CONGRESS OF PARENTS AND TEACHERS

Mr. Chairman and members of the House Subcommittee on Public Health, Science, and Commerce, the National Congress of Parents and Teachers stands squarely behind the proposals outlined in H. R. 267, introduced by Congressman J. Percy Priest, and H. R. 785, introduced by Congressman James I. Dolliver. The Local Public Health Services Act of 1949 embodies the conclusions reached by our group after careful study and repeated conferences with representative health authorities and other interested organizations.

The legislation meets the requirements of our policies, which call for maximum local control of public services and for administration of Federal grants-in-aid through regularly constituted and test qualified agencies at Federal, State, and local levels. It is designed to stimulate local initiative and to encourage efficient local organization.

Testimony given before this committee has emphasized the incredible fact that the great majority of the people of America live in communities which lack the protection of full-time public health service. Most of us have assumed the presence of safeguards which in reality are not there. It will not be possible to apply the great discoveries made by medical science for the protection of our people from the inroads of contagious and chronic diseases until we have a well-integrated system of local public health services.

This proposal is outside the realm of controversy and enjoys the support of both laymen and professional groups. The National Congress of Parents and Teachers urges your early and favorable action upon the Local Public Health Services Act of 1949, an instrument of enormous potential power for raising the general health level of the entire Nation.

STATEMENT BY MRS. JOHN E. HAYES, PRESIDENT OF THE NATIONAL CONGRESS OF PARENTS AND TEACHERS

Mr. Chairman and members of the House Subcommittee on Health, I wish to submit this statement on behalf of the National Congress of Parents and Teachers. Ours is an organization that was founded 52 years ago. Today our membership totals 5,127,896 men and women in every State of the United States, the District of Columbia, Hawaii—and even in Germany and Japan. Our enduring purposes are embodied in five objects, which are repeated in the bylaws of every one of our 31,000 local associations. These are: (1) to promote the welfare of children and youth in home, school, church, and community; (2) to raise the standards of home life; (3) to secure adequate laws for the care and protection of children and youth; (4) to bring into closer relation the home and the school, that parents and teachers may cooperate intelligently in the training of the child; and (5) to develop between educators and the general public such united efforts as will secure for every child the highest advantages in physical, mental, social, and spiritual education.

Ever since 1897—the year of our founding—the mental and physical well-being of children and youth has been our dominant concern. Then in May 1946, when a new parent-teacher administration took office, health was selected as one of the four areas of parent-teacher activity to receive major emphasis, along with school education, world understanding, and parent and family life education. It is our firm conviction that without a fair chance for good health—and by that we mean a chance equal to the best—no child can make the most of his chances for education and for effective living.

Our major objective in this area is the expansion of public health service through local units, for we believe that that is the basic health service you can offer children and the community. Because the National Congress of Parents and Teachers considers health to be one of the most pressing problems of today's world, in February 1947 we called a 2-day conference to discuss concrete ways of making better public health a reality. At considerable expense—to be exact $10,000—we brought to Chicago our national officers and all our State presidents as well as our national and State chairmen of health committees, for we were convinced that this was one of the most important conferences in parent-teacher history. Every member came prepared to analyze and discuss the proposed health bill that later became the identical bills this House committee is now considering. And we adjourned our conference in full agreement on the desirability and necessity of this legislation. The identical bills now before you for consideration represent, therefore, our fervent belief that Federal assistance to the States is absolutely essential if our people are to obtain the basic health protection they deserve.

Our organization was also prominent in the National Conference on Local Health Units that was held at Princeton, N. J., September 1947. At that gathering of representatives from leading organizations concerned with health the delegates called for an expansion of public-health services. We parent-teacher members had long been convinced of the need, but we left that meeting still more thoroughly impressed with its urgency. It was therefore at our request that a second meeting of these same organizations, some 75, took place in January 1948 to discuss how the forthright recommendations made at Princeton might be implemented. You will see from this brief history, that the bills before you are the fruit of long and careful investigation and consultation with leading health authorities.

On January 3 of this year, therefore, Congressman J. Percy Priest (Democrat), of Tennessee, introduced H. R. 267 in the House, and 2 days later, on January 5, Representative James I. Dolliver (Republican), of Iowa, introduced an identical bill, H. R. 785, thus giving tthis vital health measure bipartisan sponsorship. Both bills were introduced at the request of the National Congress of Parents and Teachers. Also at our request, it was introduced in the Senate, S. 522, on a bipartisan basis by Senator Lister Hill (Democrat), of Alabama, for himself and for Senators Virgil Chapman (Democrat), Kentucky; Paul Douglas (Democrat), Illinois; Hubert H. Humphrey (Democrat), Minnesota; Estes Kefauver (Democrat), Tennesse; Guy Cordon (Republican), Oregon; William F. Knowland (Republican), California; George W. Malone (Republican), Nevada; Leverett Saltonstall (Republican), Massachusetts; and H. Alexander Smith (Republican), New Jersey. The Senate bill, S. 522, although very similar to the Local Public Health Services Act of 1948, includes an additional provision for grants to public and other nonprofit institutions offering training in public health work.

Throughout its half century of steady growth in size and prestige, the National Congress of Parents and Teachers has followed definite policies with regard to the national legislation which it stands behind. We have never supported any measure without first giving it a careful and critical scrutiny in the light of its advantages for children and young people and for the Nation as a whole. One of the most important of the criteria on which we insist is that a bill provide for local control. Indeed, our own organization places primary emphasis on local initiative coupled with loyalty to national goals. It is a standing rule with us that "In all Federal child-welfare legislation we recommend the inclusion of provisions that will insure maximum local control." In connection with Federal grants-in-aid to the States, we support provisions that will place their administration in whatever regularly constituted Federal, State, and local agencies are best qualified, in their respective fields, to administer them. We have also written into our organization's established policy on the subject of health this statement: "We recommend increased public support for equalized health and health education opportunities for all children and youth."

Both H. R. 267 and H. R. 785, now under consideration by your committee, conform to these established policies of the National Congress of Parents and Teachers. Their purpose is to assist the States in "developing and maintaining local public health units organized to provide basic full-time public health services in all areas of the Nation and in the training of all types of personnel for local public health unit work." Federal funds are allocated to State departments of health and earmarked for local public-health services. Allotments are made to the States according to financial need and population. The bills also call for State plans to provide coverage of all areas in the State so that distribution of Federal funds will be equitable and effective. Variations in the matching ratio are based upon the average per capita incomes of the several States, so that those with lower average income levels would receive relatively greater Federal assistance than the high-income States.

When we consider that only some 10 million Americans are now living in communities having complete coverage by local full-time medical health officers, that some 40 million others have either no public health service at all or at best the services of a part-time health officer who may not even be a physician, and that the remaining 90 million Americans receive inadequate public health service, we can hardly claim that the health of the American people is being well looked after. With the statistics of the last war fresh in our memory, we certainly cannot claim that the American people are such a healthy people that they do not need better care. All of us know better than that now. This Nation is looked up to by the peoples of the world for its preeminence in the field of medicine and for its emphasis on sanitation and cleanliness. Yet so long as millions of our own people live—and rear the children who will be tomorrow's voters—under conditions of primitive public health facilities, we must bow our heads in shame. For this, gentlemen, is a national disgrace. There is no excuse for it to continue one day longer.

The health program which we are advocating before you here today will in the years to come return to us a dividend of wealth in terms of strong citizens whose sound minds and bodies will be the surest bulwark against enemies boring from within or attacking from without. At the present time we are not prepared for peacetime living—far less for war. I surely need not tell this audience that there can be no more short-sighted national policy than the continued—and deliberate—neglect of the boys and girls who are growing up today without even the minimum protection of public health services through no fault of their own or of their parents. Their continued denial of such advantages, however, will be our fault—their country's fault—unless it is remedied. The bill which we are urging you to support is far-sighted and far reaching. Its benefits will be immeasurable.

This is not a curative program; it is a preventive program. We are vitally concerned to see that it becomes a reality in time to save today's children—as well as tomorrow's. Surely it is the way of a sincere democracy to make health the rightful and inevitable heritage of every man and woman, not the accidental inheritance of the privileged few. In terms of the future welfare of this Nation, these bills are perhaps among the most important to be considered by the present Congress. Their passage will be in the highest and most statesmanlike sense of the words, a great and potent means of national defense.

Mr. PRIEST. This concludes the appearance of witnesses today, unless the Chair has overlooked someone or unless someone who was listed has come into the room in the last few minutes. Are either Dr. Ferree or Dr. Landauer present?

The committee will stand adjourned.

(Thereupon, at 4:10 p. m., the hearings were closed.)

(The following statement was submitted for the record after the hearings were concluded:)

STATEMENT CONCERNING COMMITTEE EXAMINATION INTO EUROPEAN SYSTEMS OF MEDICAL CARE

During the course of the committee hearings on a comprehensive health program for the United States, constant references were made by numerous witnesses to current and proposed foreign systems for providing medical care. The short recess by the House during the forepart of September, provided the committee with opportunity first-hand to examine into the operations and theory of certain programs in effect in Europe.

The committee, accordingly, spent 16 days between September 10–26 in an intensive and comprehensive study of the programs of three countries adjudged to be representative of different approaches to the subject, and in a brief survey of the programs of four others. The principal programs examined were those of England, Sweden, and France. Attention was also given to those of Ireland, western Germany, Switzerland, and Italy, with the chairman of the committee also viewing that of Scotland. In addition, conferences were had with the World Health Organization, located in Geneva.

The thoroughness of the study afforded the 16 committee members, and its staff, in this brief time is a tribute to the efficiency and cooperative assistance of our Public Health Service, our various embassies and legations, and the officials of foreign governments concerned, in arranging an exceedingly informative, though heavy, schedule.

In looking into the three principal programs—England with its medical assistance directly paid by the Government, Sweden with a compulsory insurance plan, and France with a voluntary insurance program—the committee held extensive conferences and visited a number of hospitals, both city and country. Lengthy discussions were had with the respective ministers of health, general practitioners, specialists, hospital heads, private foundations, laymen, and others in both public and private capacities, who are in position to speak authoritatively concerning the intent and operations of the programs in effect. In every case adequate opportunity was had for extended conferences with members of the medical profession, not only with sponsors and proponents but also with opponents of the systems now in vogue.

In addition to the impressions thus so helpfully gained, the committee was supplied with a tremendous amount of factual data, descriptive and argumentative comment, and the like which is undergoing further detailed analysis. The committee's approach to this survey of programs and theories in operation abroad has been solely that of examining them for the light which they might cast upon the sundry proposals which have been offered here to the committee for legislative consideration as to applicability in this country. The committee did not make, nor does it intend to make, the kind of study of these foreign systems which would enable it to comment on the desirability, practicability, or success of their application in the countries where they are in practice.

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